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No. (1)

In The
Supreme Court of the United States

DIXIE NATIONAL LIFE INSURANCE COMPANY AND NATIONAL FOUNDATION LIFE INSURANCE COMPANY,
Petitioners,

v.

MARTHA WARD, ON BEHALF OF HERSELF AND ALL OTHERS SIMILARLY SITUATED,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

PETITION FOR WRIT OF CERTIORARI

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 29.6 of the Rules of this Court, petitioners hereby state that:

Standard Life Insurance Company of Indiana owns 99.5% of Dixie National Life Insurance Company. Standard Life Insurance Company of Indiana's parent company is Capital Assurance Corporation. No publicly traded company owns 10% or more of Dixie National Life Insurance Company's stock.

USHEALTH Group, Inc. is the parent corporation of National Foundation Life Insurance Company. Credit Suisse Legacy, LP is the parent company of USHEALTH Group, Inc. and is the parent of Credit Suisse First Boston Private Equity, Inc. No publicly traded company owns 10% or more of National Foundation Life Insurance Company's stock.

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INTRODUCTION

In contravention of foundational principles of federalism and comity, the Fourth Circuit held, without citation to any authority, that the well-reasoned opinion of a state agency with special expertise in the subject matter is not entitled to deference. The Fourth Circuit's decision flies in the face of well-established principles of South Carolina law that courts must defer to state agency interpretations when those interpretations are made pursuant to a statutory grant of authority. The Fourth Circuit's refusal to afford the South Carolina Department of Insurance (DOI) any deference to its well-reasoned interpretation of an insurance policy provision intrusively interjects federal courts into an area deeply rooted in state law. Indeed, Congress has expressly said that the States' continued regulation of the insurance industry is in the best interest of the public. The McCarran-Ferguson Act was enacted precisely to limit federal preemption under the commerce power. Federal courts would gravely undermine that policy if permitted to do what Congress has prohibited itself from doing.

The Fourth Circuit's decision will have profound national effects. It not only upsets fundamental principles expressed in the *Erie* doctrine (by intentionally substituting federal courts' will for well-reasoned state law), but also it introduces uncertainty and unanticipated risk into a vitally important industry whose very financial health rests on risk calculations. If left standing, the Fourth Circuit's decision would undermine the common sense point that policyholders are entitled to the coverage provided in their written insurance contracts, which were reviewed and approved by the

State—no more and no less. The Fourth Circuit's decision also preempts the function of state insurance commissions by brushing aside those agencies' expertise. That federalism-compromising error is particularly egregious here. The Fourth Circuit's decision creates an untenable and illogical interpretation of the term "actual charges"—a term employed in insurance policies across this country. The result: a select few will gain a windfall for which they never contracted or sustained any loss, yet many more insureds will suffer increased insurance premiums. Even worse, insureds could be left holding policies issued by insolvent insurance companies. Accordingly, the Court should grant this petition for certiorari and reverse the decision below. In light of the clarity of the error below and its manifest importance, the Court may wish to consider summary reversal.

OPINIONS BELOW

The Fourth Circuit's decision is reported at Nos. 06-2022, 06-2054, 2007 WL 4293319 (4th Cir. Nov. 29, 2007), and reprinted in the Appendix ("App.") at 1a. The United States District Court for the District of South Carolina's decision is reported at No. 3:03-3239-JFA, 2006 WL 1529398 (D.S.C. May 10, 2006), and reprinted at App. 43a.

JURISDICTION

The Fourth Circuit rendered its decision on November 29, 2007, and denied Dixie and National's timely motion for rehearing and rehearing en banc on January 2, 2008. On March 13, 2008, the Chief Justice granted Dixie and National's request for a 45-day extension of time to file this petition for a

writ of certiorari, up to and including May 16, 2008. This Court has jurisdiction under 28 U.S.C. § 1254.

PERTINENT STATUTORY PROVISIONS

The McCarran-Ferguson Act, provides in pertinent part:

> Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States. [15 U.S.C. § 1011].
>
> ...
>
> The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business. [15 U.S.C. § 1012].

South Carolina Code, Title 38, Chapter 3, Article 1, section 110, Duties of Chief Insurance Commissioner, provides in pertinent part:

> The director or his designee has the following duties: (1) supervise and regulate the rates and service of every insurer in this State and fix just and reasonable standards, classifications, regulations, practices, and measurements of service to be observed and followed by every insurer doing business in this State; ... (2) see that all laws of this State governing insurers or relating to the business of insurance are faithfully executed and make regulations to carry out this title and all other insurance laws of this State, the enforcement or administration of which is not otherwise specifically provided for; ... (4) institute civil actions, either

through his office or through the Attorney General, relative to the business of insurance or the provisions of this title which he considers necessary to institute.

S.C. Code Ann. § 38-3-110.

Chapter 3, section 150 of the same Title provides in pertinent part:

Commissioner, assistants, or agents may conduct examinations, investigations, and hearings. All examinations or investigations provided by this title, unless otherwise provided by any other insurance laws of this State, may be conducted by the director or by one or more of his duly authorized assistants or agents....

S.C. Code Ann. § 38-3-150.

Finally, Chapter 61, section 20 of the same Title provides in pertinent part:

It is unlawful for an insurer doing business in this State to issue or sell in this State a policy, contract, or certificate until it has been filed with and approved by the director or his designee. The director or his designee may disapprove the form if it: (1) does not meet the requirements of law; (2) contains provisions which are unfair, deceptive, ambiguous, misleading, or unfairly discriminatory....

S.C. Code Ann. § 38-61-20.

STATEMENT OF THE CASE

A. Factual Background

The South Carolina legislature has expressly granted the South Carolina Department of Insurance (DOI) statutory authority to regulate the

insurance industry within that State. The DOI's mission is to protect insurance consumers, the public interest, and the insurance marketplace by ensuring the solvency of insurers; by enforcing and implementing the insurance laws of South Carolina; and by regulating the insurance industry efficiently, courteously, responsively, and fairly. The DOI is responsible for regulating 1,450 insurance companies and over 50,000 agents, brokers, adjusters, appraisers and administrators. As part of this authority, the DOI has the express duty to ensure that insurance contracts sold within the State do not contain ambiguous or misleading terms. The DOI is also entrusted to review (and approve) insurance contracts for sale within South Carolina, as well as investigating disputes between insurers and insureds. Where a proposed contract contains ambiguous terms, the DOI is obligated to prohibit its sale within the State. Insurance providers work closely with the DOI to ensure that, before they offer a policy for sale in the State, contract policy provisions and terms are unambiguous and valid under South Carolina law.

Petitioner Dixie National Life Insurance Company underwrote cancer treatment insurance policies issued to thousands of consumers in the southeastern United States, including South Carolina. The Dixie policy is a supplemental benefit insurance policy. App. 44a. Generally, supplemental insurance policies provide cash benefits to an insured for a covered loss, regardless of whether the insured has other primary health

insurance to pay for any portion of that loss.[1] The supplemental insurer therefore pays cash benefits directly to the insured upon its receipt of written proof of loss supporting the claim, regardless of whether the insured's primary health insurance policy has paid any portion of the same loss directly to the insured's health care provider. App. 4a-5a. Because both the primary and supplemental insurance policies require that the insured first sustain a loss (i.e., incur expenses for applicable medical treatment), there is no concern about an insured's "double recovery" for medical treatment covered under both the primary and supplemental policies. *Id.* Supplemental insurance policies frequently provide, as the policy at issue here provides, that when a primary health insurer pays covered medical expenses, the supplemental insurer will only pay the insured supplemental benefits measured by the health care provider's "actual charges" for the covered procedure or treatment. App. 5a.

South Carolina law required Dixie's supplemental cancer policy (the Policy) to be filed with, reviewed by, and approved for sale by the DOI. S.C. Code Ann. § 38-71-310. By approving the policy, the DOI determined that the Policy was not ambiguous, unfair, deceptive, misleading or unfairly discriminatory. *Id.* In December 1993, petitioner,

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[1] Typically, primary health insurance plans contain various calendar year deductibles, co-insurance requirements, and co-payment requirements by the insured, as well as other limitations on coverage. Insureds may use their supplemental insurance benefits to pay these costs.

National Foundation Life Insurance Company, assumed the Policy from Dixie. App. 6a.

Respondent, Martha Ward (Ward), purchased the Policy from Dixie in August 1990. App. 44a. Her husband, James Ward, was listed as an insured under the Policy. *Id.* Ward's Policy provides that certain benefits, including payments for radiation therapy and chemotherapy, are measured based upon the "actual charges" to the insured for such treatments. App. 5a-6a. For example, the Policy provides:

> We will pay for the actual charges for teleradiotherapy, using either natural or artificially propagated radiation, when used for the purpose of modification or destruction of tissue invaded by cancer. We will also pay the actual charges made for plaques or molds or the administration internally, interstitially, or intercavitarially of radium or radioisotopes in sealed sources for the purpose of modification or destruction of tissue invaded by cancer....

Id. The Policy, however, does not specifically define the term "actual charges." *Id.*

In 2001, Mr. Ward was diagnosed with prostate cancer and was treated with radiation therapy. App. 44a. During that treatment, Mr. Ward had primary heath insurance coverage under South Carolina's State Health Plan, which is a preferred provider organization (PPO) plan administered by Blue Cross Blue Shield of South Carolina (BCBS). App. 6a. Under the terms of the Wards' primary health

insurance policy, health care providers agree with BCBS, before rendering any services, to charge and accept certain pre-negotiated contract amounts as payment in full for services rendered to State Health Plan insureds. *Id.* Under the contractual terms of BCBS's agreements with health care providers, a provider is prohibited from billing an insured for any amount greater than the pre-negotiated rates they agreed to accept for their services in advance of performing such services. App. 6a-7a.

Beginning in 2002, Ward submitted claims to National under the Policy using adjusted summary of account statements that she had received from her husband's health care providers. App. 44a. Upon learning that the Wards were covered by the State Health Plan, National requested that Ward submit her husband's Explanation of Benefits (EOB) statements from BCBS because those statements reflect the pre-negotiated rates for the services rendered. App. 45a. National explained to Ward that because "any amounts written-off by a provider cannot be balance billed to insurance companies or the patient [by law], such amounts cannot be considered as actual charges." App. 60a.

Ward refused to provide her EOBs to National. App. 7a. Instead, she maintained that she was entitled to payments based on whatever amount may have been set forth on any provider's statement, regardless of whether the amount exceeded the contractually negotiated charges that the provider had agreed to accept as payment in full for services rendered. App. 62a. In other words, Ward insisted that she was entitled to benefits equaling whatever amount was listed on a provider's statement—even if that amount was never actually billed or represented

an amount that neither she, nor her primary insurance carrier, was legally obligated to pay.

On August 14, 2002, Ward sent a letter to the DOI, complaining that National had improperly refused to pay claims based on her interpretation of the term "actual charges." App. 61a. The DOI began an investigation, and ultimately rejected Ward's complaint. The DOI expressly concluded that National "handled this matter appropriately." App. 63a. In a letter ruling, the DOI stated that "[c]harges by providers that are discounted due to other contracts become the actual charges, as the discounted amount cannot be balance billed to either the insurance company or the patient." *Id.*

Not satisfied with the DOI's response, Ward filed a second complaint with the DOI, requesting "a legal definition" of the term "actual charges" under South Carolina law, as well as an "audit by [the DOI] on the reimbursement laws of cancer policies...." App. 65a-66a. In response, the DOI ruled:

> The term "actual charges" in industry-wide standards is the amount that you are legally obligated to pay for a specific service....
>
> Your Cancer Policy ... is a specified disease policy providing benefits on an expense-incurred basis. When you incur expenses, you are legally obligated to pay those expenses....
>
> Health insurance policies are not meant to provide benefits for services for which the insured person is not legally obligated to pay. Your State Health

> Plan has an agreement with certain providers to accept the Allowable Charge under the Plan as payment in full. Under the agreement, the provider cannot balance bill you for any additional amounts over the Allowable Charge as determined by the State Health Plan. Since you are not legally obligated to pay more than the State Health Plan's Allowable Charge for any specific service, National ... has requested copies of the State Health Plan's Explanation of Benefits (EOBs) to determine how much the provider has agreed to charge you.
>
> National ... is not considering the payment under the State Health Plan but rather excluding that amount that is required to be written off by the State Health Plan.

App. 67a-68a.

The DOI's interpretation of "actual charges" was entirely consistent with its previous rulings on this issue. In a letter opinion issued three years earlier, in 1999, the DOI concluded that it was proper for National to require an insured's EOB to process an "actual charges" claim under the Dixie cancer policy precisely because a "provider may not bill [the insured] more than the approved amount" for services rendered. App. 55a. The DOI also made the very same determination in 2002 before it received Ward's complaint—namely that National had properly sought EOBs from a Dixie policyholder so it could determine the actual charges of services

rendered because "[a]n insurer is not liable for charges, which an [insured] is not legally responsible for." App. 57a.

B. Proceedings Below

Notwithstanding the DOI's consistent interpretation of "actual charges" under the Policy, Ward filed this action against petitioners in South Carolina state court in March 2003. App. 46a. Dixie and National removed the action to the U.S. District Court for the District of South Carolina on October 10, 2003. *Id.* The district court twice granted Ward leave to amend her complaint. Ward's Third Amended Complaint alleged that National refused to reimburse Ward based on the "actual charges" for services rendered, and instead reimbursed Ward based on the negotiated rates between the State Health Plan and the providers. This, according to Ward, was in direct contravention of the policy.

In early 2006, Dixie and National moved for summary judgment, which the district court granted. App. 48a. The district court held that the plain and ordinary meaning of the term "actual charges" is "the charges for which the patient is liable when medical services are rendered, not the fictitious amounts indicated on the invoice that the provider does not expect the patient to pay." App. 52a. In so concluding, the district court properly deferred to the DOI's interpretation of that policy term:

> This finding is in accord with the position taken by the SCDOI. Under well-settled South Carolina law, the SCDOI's construction of the Policy is to

> be accorded respectful consideration and should not be overruled absent compelling reasons. *See, e.g., Dunton v. S.C. Bd. of Exam'rs in Optometry*, 353 S.E. 132, 133 (S.C. 1987).

Id.

Ward appealed. The DOI filed an amicus brief on behalf of Dixie and National's position and once again reiterated its longstanding interpretation of "actual charges" under the Policy. Nevertheless, on October 5, 2007, the Fourth Circuit reversed the district court, holding that the term "actual charges," as used in Ward's policy was ambiguous. App. 30a-34a. Improperly resorting to parol evidence, the Fourth Circuit concluded that "actual charges" is an ambiguous "term of art" as used in the policy and could be reasonably construed to mean either "'the amount that you are *legally obligated to pay for a specific service*," as the DOI had determined, or "the amount billed," as certain health care dictionaries provide.[2] App. 33a (internal quotation omitted) (emphasis in original). Accordingly, the court of appeals vacated the district court's grant of summary judgment and remanded for further proceedings.

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[2] Importantly, the parol evidence cited by the Fourth Circuit notes that the "actual charge may not be the same as that paid for the service by an insurance plan." App. 33a. This is entirely consistent with insurance practices and National's position, in that it recognizes the insured's calendar year deductibles, co-insurance, and co-payment requirements, although not paid under the primary health plan, are properly included as part of the medical provider's actual charge.

Petitioners and Ward both filed motions for panel rehearing. The DOI filed a second amicus brief in support of Dixie and National's motion for rehearing. On November 29, 2007, the Fourth Circuit granted Ward's motion for rehearing, vacated its original panel decision, and entered a new opinion, which not only reversed the district court's grant of summary judgment in Dixie and National's favor, but also granted summary judgment in favor of Ward. In revising its original opinion, the panel concluded that the term "actual charges" was patently ambiguous, which, under South Carolina law, is an ambiguity that must be resolved, as a matter of law, in favor of the insured. App. 12a-13a. In reaching that conclusion, however, the Fourth Circuit expressly declined to defer to the DOI's interpretation of the term "actual charges," instead, substituting its own judgment in place of the state agency's. App. 12a n.3. "National and its supporting amici, [which included the DOI,] contend that, absent compelling reasons, we must defer to the Department of Insurance's interpretation of 'actual charges.' *We disagree.*" *Id.* (emphasis added). Although the panel recognized that under South Carolina law, "an agency's interpretation of a statute it is charged with enforcing is entitled to deference," the panel concluded—despite South Carolina's broad and express statutory grant to the DOI to interpret policies—that the DOI "has no statutory mandate to pronounce the meaning of the term in an individual insurance policy." *Id.*

On December 13, 2007, Dixie and National filed a second petition for panel rehearing or rehearing *en banc*. The DOI submitted a third amicus brief in support of Dixie and National's petition. The Fourth

Circuit denied the petition for rehearing on January 2, 2008.

This petition follows.

REASONS FOR GRANTING THE WRIT

I. The Fourth Circuit's Failure To Defer To The South Carolina Department Of Insurance Improperly Interjects The Federal Courts Into An Area Of Law That Has Been Expressly Left To The States.

The South Carolina legislature has created a comprehensive regulatory scheme for the State's insurance industry. The South Carolina legislature placed the DOI at the helm of this regulatory regime. In its decision below, however, the Fourth Circuit refused to defer to the DOI's well-reasoned interpretation of an insurance policy whose content it had approved and was charged with administering. If allowed to stand, the Fourth Circuit's decision will give federal courts free rein to interject themselves into state insurance regulation, a result that is contrary to Congress's express intention that the States maintain exclusive regulatory authority over insurance matters. Indeed, Congress enacted the McCarran-Ferguson Act, "leaving insurance regulation generally to the States[,] ... to limit congressional preemption under the commerce power." *American Ins. Ass'n v. Garamendi*, 539 U.S. 396, 428 (2003). Federal courts will manifestly undermine that "legislative choice," *id.*, if they are permitted to ignore state insurance commissions' well-reasoned interpretations of insurance policy provisions.

It is axiomatic, in South Carolina and in other States, that where a state agency interprets a statute or regulation it is entrusted to enforce, that interpretation deserves the utmost respect unless it is contrary to the text's plain meaning. *See Richland County Sch. Dist. Two v. South Carolina Dep't of Ed.*, 335 S.C. 491, 498 (1999) (holding that "the deference normally afforded an administrative agency[]" will only be overruled where "the plain meaning of the proviso's language provides a compelling reason to reject [it]").[3]

Under South Carolina law, South Carolina courts give broad deference to state agencies, regardless of whether a state agency has interpreted its statute in a formal adjudication on the merits, notice-and-comment rulemaking, or in an informal policy statement. *See, e.g., South Carolina Life & Accident & Health Ins. Guar. Ass'n v. Liberty Life Ins. Co.*, 545 S.E.2d 270 (S.C. 2001) (refusing to defer to state

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[3] *See, e.g., RME Petroleum Co. v. Wyoming Dep't of Rev.*, 150 P.3d 673, 689 (Wyo. 2007) ("We will defer to an administrative agency's construction of its rules unless that construction is clearly erroneous or inconsistent with the plain meaning of the rules."); *Murphy v. District of Columbia Dep't of Employment Svcs.*, 935 A.2d 1066, 1070 (D.C. 2007) ("[An] agency's interpretation of the statute it administers is binding on this court unless it conflicts with the plain meaning of the statute."); *Dean v. Public Employees' Ret. Sys.*, 797 So.2d 830, 835 (Miss. 2000) ("An agency's interpretation of its governing law is entitled to deference, unless its interpretation is repugnant to the plain meaning ... of the statutes."); *Falk v. Beard*, 614 So.2d 1086, 1089 (Fla. 1993) ("The construction of a rule by the agency charged with its enforcement and interpretation is entitled to great weight. Courts should not depart from that construction unless it is clearly erroneous.").

agency's interpretation of a statute in an informal letter to a petitioner only because that interpretation was in direct conflict with the plain meaning of the statute); *Dunton v. South Carolina Bd. of Exam'rs In Optometry*, 353 S.E.2d 132, 133 (S.C. 1987) ("The construction of a statute by the agency charged with its administration will be accorded the most respectful consideration and will not be overruled absent compelling reasons."). Indeed, the South Carolina Supreme Court recently reaffirmed this principle of deference in *Sloan v. South Carolina Board of Physical Therapists*, 370 S.C. 452 (2006)—a case decided just one year before the Fourth Circuit's decision. In *Sloan*, the South Carolina Supreme Court reiterated that an agency's interpretation of the statute it is charged with administering deserves "the most respectful consideration[, which] should not be overruled absent compelling reasons," *id.* at 469—even though the agency interpretation at issue was "nothing more than a policy or guidance statement which does not have the force or effect of law in any individual case," *id.* at 474.

As a matter of South Carolina law, the DOI has the exclusive statutory duty to regulate insurance companies doing business within South Carolina, including the obligation to ensure that insurers offer policies that are neither ambiguous nor unfair. S.C. Code Ann. § 38-3-110. Because the DOI is a state agency that enjoys a statutory grant of authority to regulate the insurance marketplace in the State, and because it has expertise regarding insurance contracts, South Carolina courts will defer to the DOI when it speaks on an issue concerning the regulation of insurers and will not overrule the

DOI's determinations absent compelling reasons. *E.g.*, *Dunton*, 353 S.E.2d at 133.

The Fourth Circuit's decision is in irreconcilable conflict with this black-letter South Carolina law. The Fourth Circuit expressly rejected petitioners' "conten[tion] that, absent compelling reasons, [it] must defer to the Department of Insurance's interpretation of actual charges." App. 12a n.3. Instead it concluded, without citation to authority, that it was not "require[d] ... to defer to the Department's view of the matter." *Id.*

This destabilizing decision cannot be excused, as the court below attempted to do, by any claim that the DOI "has no statutory mandate to pronounce the meaning of a term in an individual insurance policy." *Id.* South Carolina law clearly provides otherwise: it grants the DOI broad regulatory authority over insurance polices sold within the State. *See* S.C. Code Ann. § 38-3-110. That duty includes an express statutory obligation to ensure that the terms of an insurance policy are unambiguous, as well as the statutory authority to refuse to approve any policies for sale in the State that contain ambiguous or misleading terms. *Id.* The DOI also has expansive statutory authority to investigate and adjudicate disputes between insurers and insureds. *See id.* § 38-3-150. In short, the DOI's regulatory authority is broad and easily encompasses the authority—if not the outright legal obligation—to interpret a provision in a previously approved insurance policy, the meaning of which is subject to dispute between an insurer and insured.

Here, Ward asked for and received a legal interpretation of the term "actual charges" from the DOI. As a result of that request, the DOI, pursuant

to its statutory authority, opened an investigation into the dispute between Ward and National and concluded that the term "actual charges" means "the amount that [insureds] are *legally obligated to pay for a specific service.*" App. 67a (emphasis in original). That is because the subject policy "provide[s] benefits on an *expense-incurred* basis." *Id.* (emphasis added). In other words, the Wards' policy only pays for expenses and losses that an insured has actually suffered. *Id.*

The DOI thus provided Ward with a reasoned interpretation of the precise policy term at issue in this case, and its interpretation was wholly consistent with its previous interpretations of the same policy term. Even assuming that the DOI's opinion letters to Ward do not, by themselves, constitute a formal, definitive ruling by the DOI, the DOI subsequently submitted three amicus briefs to the Fourth Circuit in connection in this appeal (as well as an amicus brief with the district court), each of which unequivocally affirmed and reiterated the DOI's initial rulings. Under such circumstances, "[t]here is simply no reason to suspect that the interpretation does not reflect the agency's fair and considered judgment on the matter in question." *Auer v. Robbins*, 519 U.S. 452, 462 (1997) (Secretary of Labor's interpretation of regulation set forth in amicus brief was entitled to deference); *see also Christensen v. Harris County*, 529 U.S. 576, 591 (2000) (Scalia, J., concurring) (an amicus brief cosigned by the Solicitor General and Secretary of Labor, which represents the position previously set forth by the Department of Labor in an opinion letter, is entitled to *Chevron* deference).

The Fourth Circuit's refusal to defer to the DOI's consistent, well-reasoned interpretation is inexplicable. It is manifestly contrary to South Carolina courts' admonition that agency rulings that fall within their regulatory authority and area of expertise must be given meaningful deference. The Fourth Circuit's decision seems to rest on the court's conclusion that the DOI's administering statute does not charge the DOI with the *specific* task of interpreting an *individual* term in an insurance policy. App.12a n.13. That cannot be the standard for deference. If deference is owed only where an administering statute details each and every act that a state agency must perform to carry out its legislatively-mandated duties, then the principle of agency deference will carry little force. Administering statutes, including the insurance code at issue, often grant an agency broad regulatory authority without filling in all of the details. It is in precisely such circumstances that agency deference should be at its peak. *See Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 843 (1984) ("The power of an administrative agency to administer a congressionally created ... program necessarily requires the formulation of policy and the making of rules to fill any gap left, implicitly or explicitly, by Congress.") (internal quotation omitted).

If allowed to stand, the Fourth Circuit's decision will give federal courts license to interject themselves into an area of law that Congress has expressly left to the States to regulate. Under the McCarran-Ferguson Act, Congress announced that state regulation of the insurance industry best serves "the public interest." 15 U.S.C. § 1011. That

is precisely why Congress "declare[d] that the continued regulation by the [States]" is the preferred method of regulating the insurance industry. *Id.*; *see also Lac D'Amiante du Quebec, Ltee v. American Home Assur. Co.*, 864 F.2d 1033, 1041 (3d Cir. 1988) ("In the absence of the type of comprehensive federal regulation over insurance accorded the banking, securities and commodities industries, and because of the exclusion of insurance companies from the operation of federal bankruptcy law ... the states have assumed the primary role in regulating insurance."); *cf. Chiropractic Am. v. Lavecchia*, 180 F.3d 99, 107 (3d Cir. 1999) (recognizing that "there is no federal interest in the regulation of automobile insurance, an area in which Congress has deferred to the states"). Indeed, "States, as a matter of tradition and express federal consent, have an important interest in maintaining precise and detailed regulatory schemes for the insurance industry." *Quackenbush v. Allstate Ins. Co.*, 517 U.S. 706, 733, (1996) (Kennedy, J. concurring) (citing McCarran-Ferguson).

Federal courts, therefore, should not be in the business of imposing their judgment where a state insurance commission has already spoken. *See Humana Inc. v. Forsyth*, 525 U.S. 299, 310 (1999) (recognizing that the McCarran-Ferguson Act precludes application of federal law where it "directly conflict[s] with state regulation, and when application of the federal law would ... frustrate [the] declared state policy or interfere with a State's administrative regime"). To allow a federal court to do so is at odds with fundamental principles of *Erie*—the application of state law in an independent and neutral federal forum. Indeed, this Court has

repeatedly emphasized the importance of federalism and comity, particularly when federal courts sit in diversity. It has recognized various prudential doctrines to promote the fundamental objectives of diversity jurisdiction post-*Erie*. For example, federal courts apply various forms of abstention to avoid the misapplication of state law. Under *Thibodaux* abstention, federal courts abstain from deciding state-law questions that are inherently tied to the State's "sovereign prerogative." *Louisiana Power & Light Co. v. City of Thibodaux*, 360 U.S. 25, 28 (1959). Federal courts might also abstain from deciding unresolved questions of state law where the State has created a comprehensive regulatory scheme over the subject of litigation. *Burford v. Sun Oil Co.*, 319 U.S. 315 (1943). The pivotal point is that this Court has admonished federal courts sitting in diversity to ensure that they properly apply state law as the States would apply it. And where state law is unclear, federal courts may, as a prudential matter, abstain to avoid conflicts with the States whose laws they are supposed to be applying.

It would be upside down, therefore, to say (as the Fourth Circuit tacitly did here) that federal courts may abstain on an issue of state law that remains unresolved, but may ignore settled state law as interpreted by the well-reasoned decisions of a State's agency. *Compare First Penn-Pacific Life Ins. Co. v. Evans*, 304 F.3d 345, 348 (4th Cir. 2002) ("Courts should abstain from deciding cases presenting difficult questions of state law bearing on policy problems of substantial public import whose importance transcends the result in the case then at bar, or whose adjudication in a federal forum would be disruptive of state efforts to establish a coherent

policy with respect to a matter of substantial public concern.") (internal quotations omitted), *with* App. 12a n.3 ("National and its supporting amici contend that, absent compelling reasons, we must defer to the [DOI's] interpretation of 'actual charges.' We disagree."). Such an analysis turns *Erie* on its head.

To the contrary, there is an "inherent logic of ... allowing state agencies wider deference in state law determinations." *Michigan Bell Tel. Co. v. MFS Intelenet of Mich., Inc.*, 339 F.3d 428, 433 (6th Cir. 2003); *cf. Kendra Oil & Gas, Inc. v. Homco, Ltd.*, 879 F.2d 240, 242 (7th Cir. 1989) ("[F]ederal courts will defer to the primary jurisdiction of a state agency under the principles established by *Erie,* if state courts would defer."). Deferring to state agency determinations promotes the primary objectives of diversity jurisdiction post-*Erie*—"discouragement of forum-shopping and avoidance of inequitable administration of the laws." *Hanna v. Plumer,* 380 U.S. 460, 468 (1965). If federal courts refuse to apply state-law principles of deference on questions of purely state law, it will "create[] a dual system of enforcement of state-created rights, in which the substantive rule applied to a dispute may depend on the choice of forum." *Salve Regina College v. Russell,* 499 U.S. 225, 234 (1991). Litigants should not be able (much less structurally encouraged) to select a federal forum to avoid the application of state law to their state-law breach-of-contract claims, particularly where the state agency that approved and regulates insurance contracts has already interpreted the very contract provision at issue. This salutary pro-federalism principle has all the more force where, as here, Congress has determined that such insurance contracts are best

regulated by the States. But that flouting of Congress' intent is precisely what the Fourth Circuit's decision would allow here.

Federal courts deeply undermine sound principles of federalism and comity when they refuse to defer to a state insurance agency's well-reasoned determination of an issue of purely state law. This Court should grant this petition for certiorari and reverse the decision below.

II. The Fourth Circuit's Refusal To Defer To The South Carolina Department Of Insurance's Interpretation Of The Term "Actual Charges" Is An Important Issue That Affects Insurance Policies Issued Across Many States.

When it refused to defer to the state agency's interpretation of "actual charges," the Fourth Circuit not only undermined fundamental principles of federalism, but also created a dangerous new precedent, which will affect thousands of insurance policies sold nationwide. In all of these policies, as well as many other supplemental insurance policies, the insured is reimbursed for expenses based on the health care provider's "actual charges." The Fourth Circuit's decision, if allowed to stand, will have the effect of altering the meaning of an unambiguous policy term, a meaning upon which insurers have based their respective risk calculations and set premiums. If insurance contracts are to have any meaning or value, then unambiguous provisions must be interpreted to provide the coverage contracted for—no more and no less. That point is particularly important here because the decision

below will have consequences that reach far beyond South Carolina.

First, insurance companies rely upon state insurance commissions, their primary regulatory bodies, to approve their policies. These commissions, in turn, work with insurance companies to ensure that policy provisions are not infected with ambiguity. *See, e.g.*, Ala. Code Ann. 1975 § 27-14-9 (the commissioner of insurance shall not approve a policy for sale within the State that is ambiguous); Fla. Stat. Ann. § 624.4412 (same); Ga. Code Ann. § 33-24-10 (same); La. Rev. Stat. Ann. § 22:621 (same); Miss. Code Ann. § 83-2-11 (same). When state commissions approve specific terms in a policy, that official approbation helpfully creates needed certainty within the insurance industry. This process is imperative, as it provides insurance companies a clear understanding of the risks they assume *before* selling policies to consumers. Indeed, this is the very basis upon which insurers enter into contracts with insureds. To allow a federal court to spawn uncertainty surrounding the already-approved terms of a policy introduces new risks that neither the state agency nor the insurance company can anticipate. This, in turn, would result in actuarial and financial uncertainty for insurance companies, whose entire financial health rests on calculating and managing these risks. Moreover, the contracts between insurers and insureds will be worth little more than the paper on which they are written.

Second, the Fourth Circuit's decision eviscerates the role of state insurance commissions by authoritatively interposing its judgment in lieu of that of the agencies. This is especially true where,

as here, an agency has performed its statutory obligation to make certain that a particular policy term is clear and unambiguous. *Cf. Muratore v. U.S. Office of Personnel Mgmt.*, 222 F.3d 918 (11th Cir. 2000) (deferring to Office of Personnel Management (OPM) on issue of insurance contract term because "OPM does have relevant expertise in this area because it negotiates the contracts ... and ... routinely interprets plans to determine an insurance carrier's liability"). The problem with the Fourth Circuit's approach is particularly acute where state agencies take a primary role in investigating and adjudicating disputes between insurance companies and insurers. State legislatures, including South Carolina's, have granted agencies the authority to adjudicate claims precisely because of agencies' expertise in the insurance industry. The Fourth Circuit's decision ultimately preempts the role of insurance commissions, making commission approval of an insurance policy and their resolutions of consumer complaints virtually irrelevant.

As this case demonstrates, ignoring the expertise of a state agency can lead to unsound decisions. Here, for example, the Fourth Circuit declared the term "actual charges" patently ambiguous because, according to that court, the term could mean either the amount an insured is legally obligated to pay for services or any amount a provider prints on an invoice, regardless of whether that amount is fictitious or in excess of any amount that the insured legally owes. App. 9a-15a. But the latter interpretation is patently illogical. It rests entirely on the assumption that insureds actually receive an invoice or a bill from their health care providers. This is at odds with modern medical billing practices

where consumers are rarely (if ever) directly billed for services rendered.

Finally, the Fourth Circuit's decision creates a federal precedent regarding the term "actual charges," which will affect insurance policies sold not only in South Carolina, but also in States within the Fourth Circuit and across the nation. The Fourth Circuit's opinion has already been cited positively by the Fifth Circuit. In *Guidry v. American Pub. Life Ins. Co.*, 512 F.3d 177, 184 (5th Cir. 2007), a case where the question of state agency deference was not raised, the Fifth Circuit held that under Louisiana law, the term "actual charges" in the subject supplemental insurance policy was ambiguous. It noted that its "conclusion is supported by the Fourth Circuit's recent decision in [*Ward*]." The Fifth Circuit continued:

> In *Ward*, the Fourth Circuit considered the interpretation of the same term "actual charges," as used in a similar insurance policy, and applied similar rules of contract interpretation under South Carolina law. Like us, the Fourth Circuit determined that the definition of "actual charges" advocated by the insurance companies ... was "not the only one possible when the language of the policy is considered in light of its context.

Id. In other words, the Fourth Circuit's decision (and now *Guidry*) now stand as precedent for an untenable and illogical understanding of the term "actual charges." This will have a profound financial impact on the insurance industry in this country. If

left standing, the Fourth Circuit's decision will result in higher insurance premiums across the country. And in States where insurance commissioners must approve rate increases, the Fourth Circuit's decision may lead to insolvency problems for insurance companies. While the decision will result in a windfall benefit for a few, the interests of most insureds will suffer. Needless to say, the Fourth Circuit's decision will have far-reaching effects well beyond South Carolina. This Court should grant certiorari to address a question of critical importance to insureds and insurers alike. Because of the manifest clarity of the error below, the Court may wish to consider summary reversal.

CONCLUSION

For the foregoing reasons, this Court should grant the petition for writ of certiorari. The Court may also wish to consider summary reversal.

Respectfully submitted,

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ON REHEARING

UNPUBLISHED

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 06-2022

MARTHA WARD, ON BEHALF OF HERSELF AND ALL OTHERS SIMILARLY SITUATED,

Plaintiff - Appellant,

versus

DIXIE NATIONAL LIFE INSURANCE COMPANY; NATIONAL FOUNDATION LIFE INSURANCE COMPANY,

Defendants - Appellees,

and

PALMETTO MARKETING ASSOCIATES, INCORPORATED;
PATTI JENKINS,

Defendants.

SOUTH CAROLINA DEPARTMENT OF INSURANCE;
AMERICA'S HEALTH INSURANCE PLANS, INCORPORATED,

Amici Supporting Appellees.

No. 06-2054

MARTHA WARD, ON BEHALF OF HERSELF AND ALL OTHERS SIMILARLY SITUATED,
Plaintiff - Appellee,

versus

NATIONAL FOUNDATION LIFE INSURANCE COMPANY,
Defendant - Appellant,

DIXIE NATIONAL LIFE INSURANCE COMPANY,
Defendant - Appellee,

and

PALMETTO MARKETING ASSOCIATES, INCORPORATED;
PATTI JENKINS,
Defendants.

SOUTH CAROLINA DEPARTMENT OF INSURANCE;
AMERICA'S HEALTH INSURANCE PLANS, INCORPORATED,
Amici Supporting Appellant.

Appeals from the United States District Court for the District of South Carolina, at Columbia. Joseph F. Anderson, Jr., Chief District Judge. (3:03-cv-

03239-JFA)

Argued: May 23, 2007 Decided: October 5, 2007
Decided on Rehearing: November 29, 2007

Before MICHAEL and TRAXLER, Circuit Judges, and WIDENER,[1] Senior Circuit Judge.

Vacated in part, affirmed in part, dismissed in part, and remanded by unpublished per curiam opinion.

PER CURIAM:

Plaintiff Martha Ward sued National Foundation Life Insurance Company (National) and Dixie National Life Insurance Company (Dixie), asserting that National refused to pay the full amount of benefits owed under supplemental cancer insurance policies that were issued by Dixie and later assigned to National. The district court certified a statewide (South Carolina) plaintiff class rather than the multistate class Ward sought to represent, and the court later granted summary judgment in favor of National on the breach of contract claims. Ward appealed and National cross-appealed. In a prior opinion, we concluded that although the district

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[1] Judge Widener heard oral argument in this case but died prior to the time the decision was filed. The decision is filed by a quorum of the panel. 28 U.S.C. § 46(d).

court properly limited the plaintiff class to South Carolina residents, the court improperly granted summary judgment on the breach of contract claims, and we remanded for further proceedings on those claims. We dismissed National's cross-appeal without prejudice. *See Ward v. Dixie Nat'l Life Ins. Co.*, 2007 WL 2914954 (4th Cir. Oct. 5, 2007).

Ward filed a petition for rehearing, and National, supported by various amici, filed a petition for rehearing and rehearing *en banc*. We granted Ward's petition for panel rehearing and denied National's petition for rehearing, thus vacating our prior opinion.[2] *See* Fourth Circuit I.O.P. 40.2. Dispensing with further briefing and argument, we now vacate the district court's decision granting summary judgment in favor of National, and we remand with instructions for the district court to instead enter judgment in favor of Ward on the breach of contract claims. In light of our remand, we conclude that it would be premature for us to consider the class certification issue. We therefore dismiss without prejudice National's cross-appeal.

I.

In August 1990 Ward purchased a cancer treatment benefit policy from Dixie covering both herself and her husband. Ward's policy is a type of supplemental insurance under which direct payments are made to the policyholder when an insured patient undergoes covered cancer

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[2] Because no member of the court called for a vote on National's petition for rehearing en banc, the petition was denied. *See* Fourth Circuit Local Rule 35(b).

treatments. Benefits under this kind of policy are paid regardless of whether the patient has other insurance sufficient to cover all medical expenses. When the patient has other insurance covering cancer treatments, the policyholder is able to retain the money received as a result of the supplemental coverage.

Benefits under Ward's policy vary as to the procedure performed. In some sections the policy provides clear caps as to the maximum benefit to be paid. For example, the policy provides a "Schedule of Operations" listing the maximum amount to be paid — ranging from $150 for skin excisions to $3000 for removal of an intracardiac tumor — for a variety of operations. In many other sections of the policy no dollar amounts are provided, and benefits are calculated in relation to the "actual charges" for the covered procedures. Section (F) of the policy, titled "X-ray Therapy, Radium Therapy, Radiation Therapy, and Chemotherapy Benefit," provides an example of this language:

> We will pay the actual charges for teleradiotherapy, using either natural or artificially propagated radiation, when used for the purpose of modification or destruction of tissue invaded by cancer. We will also pay the actual charges made for plaques or molds or the administration internally, interstitially, or intracavitarially of radium or radioisotopes in sealed sources for the purpose of modification or destruction of tissue invaded by cancer. We will also pay the actual

> charges for cancericidal chemical substances and the administration thereof for the purpose of the modification or destruction of tissue invaded by cancer.

J.A. 221. Although the phrase is used repeatedly throughout the policy, no definition for "actual charges" is provided.

Dixie assigned Ward's policy to National in 1994. In 2001 Ward began filing claims under the policy after her husband, James Ward (James), was diagnosed with prostate cancer and started receiving treatment. Shortly thereafter, a dispute between Ward and National arose over how benefits paid in the amount of the "actual charges" are calculated.

For a number of years after the assignment, National appears to have calculated benefits in the same manner that Dixie had previously done. Specifically, when the benefit owed was based on the "actual charges," Dixie paid the benefit based on the amounts billed to patients by their medical providers. Dixie paid such amounts even though providers often have agreements with certain insurers to accept as payment-in-full an amount less than that reflected on the patient's bill. In this case, for example, James's primary health insurance is provided through a plan administered by Blue Cross and Blue Shield of South Carolina (BCBS). Regardless of the amounts billed to James, his medical providers have an agreement with BCBS that requires them to accept a discounted amount as payment-in-full for services rendered to BCBS insureds. This agreement prohibits providers from

attempting to collect an amount in excess of the pre-negotiated, discounted fee from BCBS insureds such as James.

Toward the end of the year in 2001, National changed its benefit payment practice. When Ward submitted claims for James's treatments in 2002, she was told that she would have to submit an explanation of benefits (EOB) statement. By viewing the EOB, National would be able to determine what the pre-negotiated discount rate was for James's treatments and calculate benefits in light of this reduced amount. Ward refused to provide National with the EOB statements because she contended that under the terms of her policy, the "actual charge" was reflected in the nondiscounted bill that she received rather than in the EOB.

On March 7, 2003, after Ward was unable to resolve the dispute, she filed an action in the Court of Common Pleas for Richland County, South Carolina, against both Dixie and National. The defendants removed the action to federal court on October 10, 2003. On September 15, 2004, Ward moved to certify a plaintiff class consisting of

> all persons insured under cancer policies from Defendant Dixie National Life Insurance Company where Dixie promised to pay to the insured the "actual charges" incurred for certain medical services, but instead paid not the actual charges but rather the (lesser) amount that the insured's primary health insurer negotiated with the healthcare provider to pay for the medical procedure[.]

S.A. 7. On May 5, 2005, the district court certified a class of South Carolina residents. The court limited the class to South Carolina residents based on its understanding of South Carolina's door-closing statute, S.C. Code Ann. § 15-5-150. Ward, with permission of the court, filed a third amended complaint on September 27, 2005, asserting claims for (1) breach of contract against both Dixie and National; (2) bad faith refusal to pay against National; and (3) breach of contract accompanied by a fraudulent Act against National. Ward later abandoned the bad faith claim. Cross-motions for summary judgment followed. In addition, National filed a motion, joined by Dixie, to decertify the statewide class.

On May 10, 2006, the district court granted National's motion for summary judgment while denying Ward's. The court concluded that under South Carolina contract law, the phrase "actual charges" is not ambiguous and must be read to mean "the charges for which the patient is liable when medical services are rendered, not the fictional amounts indicated on the invoice that the provider does not expect the patient to pay." J.A. 1074. Because Ward did not prevail on her breach of contract claims, the joint motion to decertify the class and Dixie's motion for summary judgment were denied as moot.

Ward appeals both the grant of summary judgment to National as well as the district court's decision to limit class membership to South Carolina residents. National has filed a cross-appeal contesting the district court's decision to certify even a statewide class.

II.

We begin with Ward's argument that the district court erred in concluding that, as used in her policy, the unambiguous meaning of the phrase "actual charges" is the discounted amount that medical providers have agreed to accept as full payment pursuant to a third-party agreement with another insurer. Under South Carolina law when a term has a "plain, ordinary, and popular meaning," courts must interpret the term to give effect to that ordinary usage. *Century Indem. Co. v. Golden Hills Builders, Inc.*, 561 S.E.2d 355, 358 (S.C. 2002). When a term has a plain meaning and that meaning is "clear and unambiguous, the language [of the contract] alone determines the contract's force and effect." *Schulmeyer v. State Farm Fire & Cas. Co.*, 579 S.E.2d 132, 134 (S.C. 2003). Of course not all terms are susceptible to plain and ordinary definition because of the simple fact that they are not popularly used. As a result, a contract term is ambiguous when it lacks a plain definition and is "capable of more than one meaning when viewed objectively by a reasonably intelligent person who has examined the context of the entire integrated agreement and who is cognizant of the customs, practices, usages and terminology as generally understood in the particular trade or business." *Hansen v. United Servs. Auto. Ass'n*, 565 S.E.2d 114, 117-18 (S.C. 2002).

In the district court's endeavor to discern the plain meaning of "actual charges" as used in Ward's policy, it reasoned that the word "actual" should be given a separate meaning from the word "charges." Because the district court understood the word

"actual" to mean something that is real or true, it concluded that "actual charges" means the amounts for which the patient is truly liable as opposed to "the fictional amounts indicated on the invoice that the provider does not expect the patient to pay." J.A. 1074. We disagree both with the district court's interpretive approach as well as the conclusion that it reached. The definition settled on by the district court is not the only one possible when the language of the policy is considered in light of its context. As we explain below, the meaning of the phrase "actual charges" as used in Ward's policy is ambiguous.

First, even under the district court's approach — defining each word separately and then putting those definitions together — another meaning can reasonably be found. The words "actual charges" could also be understood to mean the amount shown on the bill sent to the patient regardless of whether this amount is the same as the amount actually owed. Viewed from within the four corners of the policy, the phrase is ambiguous as there is nothing to indicate whether "actual charges" is best understood to mean the amount actually billed or the amount actually owed. *See Conner v. Am. Pub. Life Ins. Co.*, 448 F. Supp.2d 762, 766 (N.D. Miss. 2006) (finding "inherent ambiguity in the undefined term 'actual charges'"); *Metzger v. Am. Fid. Assur. Co.*, No. CIV-05-1387-M, 2006 U.S. Dist. LEXIS 70061, at *13 (W.D. Okla. Sept. 26, 2006) (same).

Second, we disagree with the assertion that the district court was correct "in considering ordinary dictionary definitions" of both "actual" and "charges." Appellees' Br. at 21. We conclude that a person "who is cognizant of the customs, practices, usages and

terminology as generally understood" in the health insurance industry would regard "actual charges" as a term of art rather than two words to be separately defined. *Hansen*, 565 S.E.2d at 117. The words are used throughout the insurance policy together as a phrase — a phrase that neither appears in a standard dictionary nor has an ordinary, popular usage. Contrary to the defendants' contention, South Carolina's principles of contract interpretation in no way prohibit courts from reading a phrase as a term of art if that is how it would be regarded by an objective observer well-versed in medical insurance terminology. *See Frazier v. Badger*, 603 S.E.2d 587, 591 (S.C. 2004).

Third, even when viewed as a term of art, the phrase remains ambiguous. Prior to filing this lawsuit, Ward wrote to the South Carolina Department of Insurance and asked to be provided with a legal definition of "actual charge." A representative of the Department wrote back explaining that "[t]he term 'actual charge' in industry-wide standards is the amount that you are *legally obligated to pay for a specific service*." J.A. 611 (emphasis in original). In contrast to the view taken by the Department of Insurance, numerous health care dictionaries define "actual charge" as the amount billed. *See, e.g., Mosby's Medical, Nursing, and Allied Health Dictionary* 26 (4th ed. 1994) ("actual charge, the amount actually charged or billed by a medical practitioner for a service. The actual charge may not be the same as that paid for the service by an insurance plan."); Lee Hyde, *The McGraw-Hill Essential Dictionary of Health Care* 133 (1988) ("actual charge. the amount a physician

or other practitioner actually *bills* a patient or his insurance for a medical *service* or *procedure*.") (emphasis in original). Because the policy itself does not indicate which definition was intended by the parties, we conclude that its meaning is ambiguous.[3]

We must now determine what remedy flows from our conclusion that the insurance policy is ambiguous. In a typical contract dispute, the meaning of an ambiguous contract is a question of fact to be resolved by the jury. *See, e.g., Café Assocs., Ltd. v. Gerngross*, 406 S.E.2d 162, 164 (S.C. 1991) ("As a general rule, written contracts are to be construed by the Court; but where a contract is ambiguous or capable of more than one construction, the question of what the parties intended becomes one of fact, and the question should be submitted to the jury."). Although statements of that general rule appear in cases involving insurance disputes, *see Waters v. S. Farm Bureau Life Ins. Co.*, 617 S.E.2d 385, 388 (S.C. Ct. App. 2005), only *latent* ambiguities in an insurance policy are resolved by a jury; *patent*

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[3] National and its supporting amici contend that, absent compelling reasons, we must defer to the Department of Insurance's interpretation of "actual charges." We disagree. Although an agency's interpretation of a statute it is charged with enforcing is entitled to deference, *see Dunton v. S.C. Bd. of Examiners in Optometry*, 353 S.E.2d 132, 133 (S.C. 1987), the Department of Insurance has no statutory mandate to pronounce the meaning of a term in an individual insurance policy. We are of course interested in the Department's position, but South Carolina law does not in this case require us to defer to the Department's view of the matter.

ambiguities must be resolved in favor of the insured. *See Cogdill v. Equity Life & Annuity Co.*, 203 S.E.2d 674, 677 (S.C. 1974); *Hann v. Carolina Cas. Ins. Co.*, 167 S.E.2d 420, 423 (S.C. 1969). Accordingly, if the ambiguity in this case is patent, the district court should have granted summary judgment in favor of Ward on the breach of contract claims. If the ambiguity is latent, the meaning of the policy must be determined by a jury on remand.

A patent ambiguity is one where the uncertainty as to meaning "arises upon the words of the will, deed, or other instrument as looked at in themselves, and before any attempt is made to apply them to the object which they describe." *Hann*, 167 S.E.2d at 422 (quoting *Jennings v. Talbert*, 58 S.E. 420, 421 (S.C. 1907)); *cf. Stone Container Corp. v. Hartford Steam Boiler Inspection & Ins. Co.*, 165 F.3d 1157, 1162 (7th Cir. 1999) ("A patent ambiguity in a contract is one that is apparent from just reading the contract."). With a latent ambiguity, "the uncertainty arises, not upon the words of the will, deed, or other instrument as looked at in themselves, but upon those words when applied to the object or subject which they describe." *Hann*, 167 S.E.2d at 422. A latent ambiguity thus "does not appear on the face of the words used, nor is its existence known until those words are brought into contact with collateral facts." *Hastings v. Union Fire Ins. Co.*, 125 S.E. 923, 924 (S.C. 1924) (internal quotation marks omitted); *cf. Stone Container Corp.*, 165 F.3d at 1162 ("A latent ambiguity arises when, although the contract is clear 'on its face,' anyone knowing the background would know that it didn't mean what it seems to mean.").

We believe that the phrase "actual charges" is patently ambiguous. The phrase is susceptible of more than one reasonable interpretation, and the uncertainty of meaning arises thus from the phrase itself, not from the application of the phrase to collateral facts. *See Cogdill*, 203 S.E.2d at 677 (concluding that "lame back" as used in a policy provision limiting disability benefits could plausibly be construed in more than one way and that the phrase was patently ambiguous); *Hastings*, 125 S.E. at 924 (finding latent ambiguity in fire insurance policy that covered two barns because the insured's property included two traditional barns and an abandoned tenant house used by the insured as a barn).

Because the ambiguity is patent, construction of the policy is for the court rather than a jury. *See Cogdill*, 203 S.E.2d at 677; *Hann*, 167 S.E.2d at 423. South Carolina law very clearly requires us to resolve the ambiguity in favor of the insured. *See Helena Chem. Co. v. Allianz Underwriters Ins. Co.*, 594 S.E.2d 455, 459 (S.C. 2004) ("Where the words of an insurance policy are capable of two reasonable interpretations, the construction most favorable to the insured should be adopted."); *Hann*, 167 S.E.2d at 423 ("It is settled beyond cavil in this jurisdiction that the terms of an insurance policy should be construed most liberally in favor of the insured, and that in case of conflict or ambiguity, a construction will not be adopted that defeats recovery if the policy is reasonably susceptible of a meaning that will permit recovery. We uniformly give the insured the benefit of any doubt in the construction of the terms used in an insurance policy."). Accordingly, we

vacate the district court's grant of summary judgment to National and remand with instructions that the district court enter summary judgment in favor of Ward on her breach of contract claims.

III.

A.

We now turn to the question of whether the district court properly limited the class of plaintiffs to those who, like Ward, are residents of South Carolina. In her motion for class certification, Ward made clear that she sought to represent persons residing throughout the southern United States who had bought policies from Dixie that were later assigned to National. Because the proposed class included non-residents of South Carolina, the district court requested briefing from the parties on the effect of South Carolina's door closing statute, S.C. Code Ann. § 15-5-150, on the potential out-of-state class members. That statute provides:

> An action against a corporation created by or under the laws of any other state government or country may be brought in the circuit court:
>
> (1) By any resident of this State for any cause of action; or
>
> (2) By a plaintiff not a resident of this State when the cause of action shall have arisen or the subject of the action shall be situated within this state.

S.C. Code Ann. § 15-5-150. As recently reinterpreted by the Supreme Court of South Carolina in *Farmer v. Monsanto Corp.*, 579 S.E.2d 325 (S.C. 2003), § 15-

5-150 determines the capacity of a party to sue. Furthermore, *Farmer* held that "§ 15-5-150 controls the eligibility of class members in a class action where the defendant is a foreign corporation." 579 S.E.2d at 559. For suits in South Carolina state court, the effect of Farmer is to limit class membership to those persons who would have had capacity to sue for themselves.

In ruling on Ward's motion for class certification, the district court concluded that § 15-5-150 prevented Ward from representing out-of-state plaintiffs. The district court reached this conclusion by relying on our prior decisions stating that "a South Carolina federal court exercising diversity jurisdiction must apply § 15-5-150 'unless there are affirmative countervailing federal considerations.'" *Proctor & Schwartz, Inc. v. Rollins*, 634 F.2d 738, 739-40 (4th Cir. 1980) (quoting *Szantay v. Beech Aircraft Corporation*, 349 F.2d 60, 64 (4th Cir. 1965)). Our decisions in *Proctor & Schwartz* and *Szantay*, however, interpreted the door-closing statute in light of the then-prevailing understanding that § 15-5-150 restricted not capacity to sue but the subject matter jurisdiction of state courts. In Farmer the Supreme Court of South Carolina overruled its prior cases stating that § 15-5-150 dealt with jurisdiction.

In this case, we do not find it necessary to decide what effect the reinterpreted door-closing statute has on class membership in suits being heard in South Carolina federal courts sitting in diversity. This is so because, as we discuss next, Ward has failed to establish that the proposed multistate class

meets Rule 23(b)(3)'s requirement that common legal issues predominate.

B.

Fed. R. Civ. P. 23 sets the requirements for class certification. First, Rule 23(a) provides that certification is proper only if

> (1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class.

Fed. R. Civ. P. 23(a). Once Rule 23(a)'s requirements of numerosity, commonality, typicality, and representational adequacy are met, the proposed class must still satisfy one of three additional requirements for certification under Rule 23(b). Because Ward sought class certification under Rule 23(b)(3), she was required to show that

> questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy.

Fed. R. Civ. P. 23(b)(3). The predominance requirement under Rule 23(b)(3) "is similar to but 'more stringent' than the commonality requirement

of Rule 23(a)." *Thorn v. Jefferson-Pilot Life Ins. Co.*, 445 F.3d 311, 319 (4th Cir. 2006) (quoting *Lienhart v. Dryvit Sys.*, 255 F.3d 138, 146 n. 4 (4th Cir. 2001)). The party seeking class certification bears the burden of establishing all Rule 23 requirements. *In re A.H. Robins Co.*, 880 F.2d 709, 728 (4th Cir. 1989).

In her class certification memorandum, Ward stated that "members of the Class are dispersed throughout the southern United States." S.A. 12. She further noted that "Dixie marketed and sold cancer policies in at least seven states other than South Carolina, including Alabama, Florida, Georgia, Louisiana, Mississippi, Tennessee, and Texas." *Id.* Although Ward's multistate class purported to include "at a minimum, thousands of persons" across the southern United States, Ward never identified what state law would apply to the claims of absent class members who are not residents of South Carolina and whose claims have no connection to that state. *Id.* In a class action potentially governed by the laws of multiple states, identifying the applicable body or bodies of state law is critical because "variations in state law may swamp any common issues and defeat predominance." *Castano v. American Tobacco Co.*, 84 F.3d 734, 741 (5th Cir. 1996). Ward has the burden of showing "that common questions of law predominate, and [she] cannot meet this burden when the various laws have not been identified and compared." *Gariety v. Grant Thornton, LLP*, 368 F.3d 356, 370 (4th Cir. 2004); *see also Cole v. GMC*, 484 F.3d 717, 730 (5th Cir. 2007) (decertifying a class because "[p]laintiffs have failed to adequately address, much less extensively analyze, [ ] variations

in state law") (internal quotation marks and citation omitted).

Because the district court ruled on the effect of the door-closing statute before addressing the merits of Ward's motion for class certification, it did not decide whether the proposed multistate class meets the requirements of both Rule 23(a) and Rule 23(b)(3). Even assuming that this proposed class could satisfy the requirements of Rule 23(a), Ward has not established that the multistate class satisfies Rule 23(b)(3)'s requirement that common questions of law predominate. Specifically, Ward failed to identify and compare the applicable state laws. When a plaintiff seeking certification fails to provide this analysis, it is not possible for the district court to determine whether any variations in state law "pose 'insuperable obstacles' to certification" of a multistate class. *Spence v. Glock, GES.m.b.H.*, 227 F.3d 308, 313 (D.C. Cir. 2000) (quoting *Walsh v. Ford Motor Co.*, 807 F.2d 1000, 1017 (D.C. Cir. 1986)). The need in this case to identify all governing state laws and compare any variations is underscored by the decisions in two recent cases where plaintiffs in states within the proposed geographic class made claims materially similar to Ward's. In contrast to our decision today under South Carolina law, two district courts applying contract law principles of Alabama and Louisiana concluded that the meaning of "actual charges" is unambiguous as a matter of law. *See Claybrook v. Cent. United Life Ins. Co.*, 387 F. Supp.2d 1199, 1203 (M.D. Ala. 2005); *Jarreau v. Cent. United Life Ins. Co.*, No. 05-83-FJP-SCR, 2006 U.S. Dist. LEXIS 51196 at *2 (M.D. La. May 16, 2006). In light of

Ward's failure to show that common issues of law would be predominant in a multistate class, we affirm the decision of the district court to limit class membership to South Carolina residents regardless of the effect of the door-closing statute. *See United States v. Smith*, 395 F.3d 516, 519 (4th Cir. 2005) ("We are not limited to evaluation of the grounds offered by the district court to support its decision, but may affirm on any grounds apparent from the record.").

IV.

We now turn to the cross-appeal filed by National, one of the defendants. National claims that the district court abused its discretion in certifying even a statewide class because: (1) the class is not sufficiently numerous; (2) Ward is neither a typical nor adequate class representative; and (3) individual issues will predominate the determination of class members' claims. On May 19, 2005, after the statewide class had been certified but before any party had filed a motion for summary judgment, National and Dixie petitioned this court to review the district court's certification order pursuant to Fed. R. Civ. P. 23(f). This rule grants us the discretion to entertain appeals from class certification orders prior to the entry of a final judgment. *See Lienhart*, 255 F.3d at 145. Our court applies a five-factor test to guide our discretion in deciding whether to hear such interlocutory appeals:

> (1) whether the certification ruling is likely dispositive of the litigation; (2) whether the district court's certification decision contains a substantial weakness; (3) whether the appeal will

> permit the resolution of an unsettled legal question of general importance; (4) the nature and status of the litigation before the district court (such as the presence of outstanding dispositive motions and the status of discovery); and (5) the likelihood that future events will make appellate review more or less appropriate.

Id. In their Rule 23(f) petition, the defendants raised the same objections to the class certification order that National now asserts in this appeal. We denied the interlocutory petition for review on June 23, 2005.

National's cross-appeal of the class certification is before us as a result of the appeal taken by the plaintiff, Ward, from a final judgment, namely, the summary judgment awarded to defendant National. Because we have decided to vacate that judgment and remand the case for further proceedings, National's current challenge to class certification is procedurally akin to the earlier interlocutory appeal. This circumstance leads us to conclude that it would be premature for us to address the class certification issue. Earlier, when the district court certified the statewide class, it explicitly reserved its authority to decertify or modify the class at a future date. *See McNamara v. Felderhof*, 410 F.3d 277, 281 (5th Cir. 2005) (noting that under Rule 23(c)(1)(C) the district court on remand "is free to reconsider its class certification order as often as necessary before judgment."). The defendants went on to file motions for summary judgment and for decertification of the statewide class. After the district court granted

summary judgment to National, the pending motion to decertify was denied as moot. Now, in light of the remand, the district court will be able to consider the motion to decertify. Accordingly, we dismiss without prejudice the cross-appeal filed by National. *Cf. Baskin v. Hawley*, 810 F.2d 370, 371 (2d Cir. 1987) ("Prudential considerations lead to our conclusion that these appeals should be dismissed as premature notwithstanding the fact that they are taken from what was, at that time, a 'final decision[ ]' within the meaning of 28 U.S.C. § 1291.") (alteration in original).

V.

In sum, we conclude that the meaning of the phrase "actual charges" as used in Ward's policy is patently ambiguous. We therefore vacate the district court's grant of summary judgment to National and remand with instructions for the district court to grant summary judgment to Ward on the breach of contract claims. We affirm, albeit on alternate grounds, the district court's decision to limit class membership to South Carolina residents. Finally, we dismiss without prejudice the cross-appeal filed by National challenging the district court's certification of a statewide class.

VACATED IN PART,
AFFIRMED IN PART,
DISMISSED IN PART,
AND REMANDED

UNPUBLISHED

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 06-2022

MARTHA WARD, ON BEHALF OF HERSELF AND ALL OTHERS SIMILARLY SITUATED,

Plaintiff - Appellant,

versus

DIXIE NATIONAL LIFE INSURANCE COMPANY; NATIONAL FOUNDATION LIFE INSURANCE COMPANY,

Defendants - Appellees,

and

PALMETTO MARKETING ASSOCIATES, INCORPORATED; PATTI JENKINS,

Defendants.

SOUTH CAROLINA DEPARTMENT OF INSURANCE; AMERICA'S HEALTH INSURANCE PLANS, INCORPORATED,

Amici Supporting Appellees.

No. 06-2054

MARTHA WARD, ON BEHALF OF HERSELF AND ALL OTHERS SIMILARLY SITUATED,

Plaintiff - Appellee,

versus

NATIONAL FOUNDATION LIFE INSURANCE COMPANY,

Defendant - Appellant,

DIXIE NATIONAL LIFE INSURANCE COMPANY,

Defendant - Appellee,

and

PALMETTO MARKETING ASSOCIATES, INCORPORATED; PATTI JENKINS,

Defendants.

SOUTH CAROLINA DEPARTMENT OF INSURANCE; AMERICA'S HEALTH INSURANCE PLANS, INCORPORATED,

Amici Supporting Appellant.

Appeals from the United States District Court for the District of South Carolina, at Columbia. Joseph F. Anderson, Jr., Chief District Judge. (3:03-cv-03239-JFA)

Argued: May 23, 2007 Decided: October 5, 2007

Before MICHAEL and TRAXLER, Circuit Judges, and WIDENER,** Senior Circuit Judge.

Reversed in part, affirmed in part, dismissed in part, and remanded by unpublished per curiam opinion.

PER CURIAM:

The named plaintiff in this diversity class action, Martha Ward, asserts that National Foundation Life Insurance Company (National) refuses to pay the full amount of benefits owed under supplemental cancer insurance policies that were issued by Dixie National Life Insurance Company (Dixie) and later assigned to National. At the center of the dispute is the parties' disagreement over the meaning of the policy language ("actual charges") used to determine benefits. We disagree with the district court's conclusion that, as used in Ward's policy, the phrase "actual charges" has an unambiguous meaning, and we therefore vacate the summary judgment granted to National and remand the case for further proceedings.

** Judge Widener heard oral argument in this case but died prior to the time the decision was filed. The decision is filed by a quorum of the panel. 28 U.S.C. § 46(d).

Although the district court certified a statewide (South Carolina) plaintiff class, Ward seeks to represent a multistate class. Because we conclude that Ward has failed to show that the proposed multistate class satisfies Rule 23(b)(3)'s requirement that common legal issues are predominant, we affirm the district court's decision limiting membership in the plaintiff class to those who, like Ward, are South Carolina residents. In its cross-appeal National asserts that even a statewide class is improper. In light of our remand for further proceedings, we conclude that it would be premature for us to consider the class certification issue. We therefore dismiss without prejudice National's cross-appeal.

I.

In August 1990 Ward purchased a cancer treatment benefit policy from Dixie covering both herself and her husband. Ward's policy is a type of supplemental insurance under which direct payments are made to the policyholder when an insured patient undergoes covered cancer treatments. Benefits under this kind of policy are paid regardless of whether the patient has other insurance sufficient to cover all medical expenses. When the patient has other insurance covering cancer treatments, the policyholder is able to retain the money received as a result of the supplemental coverage.

Benefits under Ward's policy vary as to the procedure performed. In some sections the policy provides clear caps as to the maximum benefit to be paid. For example, the policy provides a "Schedule of Operations" listing the maximum amount to be

paid — ranging from $150 for skin excisions to $3000 for removal of an intracardiac tumor — for a variety of operations. In many other sections of the policy no dollar amounts are provided, and benefits are calculated in relation to the "actual charges" for the covered procedures. Section (F) of the policy, titled "X-ray Therapy, Radium Therapy, Radiation Therapy, and Chemotherapy Benefit," provides an example of this language:

> We will pay the actual charges for teleradiotherapy, using either natural or artificially propagated radiation, when used for the purpose of modification or destruction of tissue invaded by cancer. We will also pay the actual charges made for plaques or molds or the administration internally, interstitially, or intracavitarially of radium or radioisotopes in sealed sources for the purpose of modification or destruction of tissue invaded by cancer. We will also pay the actual charges for cancericidal chemical substances and the administration thereof for the purpose of the modification or destruction of tissue invaded by cancer.

J.A. 221. Although the phrase is used repeatedly throughout the policy, no definition for "actual charges" is provided.

Dixie assigned Ward's policy to National in 1994. In 2001 Ward began filing claims under the policy after her husband, James Ward (James), was

diagnosed with prostate cancer and started receiving treatment. Shortly thereafter, a dispute between Ward and National arose over how benefits paid in the amount of the "actual charges" are calculated.

For a number of years after the assignment, National appears to have calculated benefits in the same manner that Dixie had previously done. Specifically, when the benefit owed was based on the "actual charges," Dixie paid the benefit based on the amounts billed to patients by their medical providers. Dixie paid such amounts even though providers often have agreements with certain insurers to accept as payment-in-full an amount less than that reflected on the patient's bill. In this case, for example, James's primary health insurance is provided through a plan administered by Blue Cross and Blue Shield of South Carolina (BCBS). Regardless of the amounts billed to James, his medical providers have an agreement with BCBS that requires them to accept a discounted amount as payment-in-full for services rendered to BCBS insureds. This agreement prohibits providers from attempting to collect an amount in excess of the pre-negotiated, discounted fee from BCBS insureds such as James.

Toward the end of the year in 2001, National changed its benefit payment practice. When Ward submitted claims for James's treatments in 2002, she was told that she would have to submit an explanation of benefits (EOB) statement. By viewing the EOB, National would be able to determine what the pre-negotiated discount rate was for James's treatments and calculate benefits in light of this reduced amount. Ward refused to

provide National with the EOB statements because she contended that under the terms of her policy, the "actual charge" was reflected in the non-discounted bill that she received rather than in the EOB.

On March 7, 2003, after Ward was unable to resolve the dispute, she filed an action in the Court of Common Pleas for Richland County, South Carolina, against both Dixie and National. The defendants removed the action to federal court on October 10, 2003. On September 15, 2004, Ward moved to certify a plaintiff class consisting of

> all persons insured under cancer policies from Defendant Dixie National Life Insurance Company where Dixie promised to pay to the insured the "actual charges" incurred for certain medical services, but instead paid not the actual charges but rather the (lesser) amount that the insured's primary health insurer negotiated with the healthcare provider to pay for the medical procedure[.]

S.A. 7. On May 5, 2005, the district court certified a class of South Carolina residents. The court limited the class to South Carolina residents based on its understanding of South Carolina's door-closing statute, S.C. Code Ann. § 15-5-150. Ward, with permission of the court, filed a third amended complaint on September 27, 2005, asserting claims for (1) breach of contract against both Dixie and National; (2) bad faith refusal to pay against National; and (3) breach of contract accompanied by a fraudulent Act against National. Ward later

abandoned the bad faith claim. Cross-motions for summary judgment followed. In addition, National filed a motion, joined by Dixie, to decertify the statewide class.

On May 10, 2006, the district court granted National's motion for summary judgment while denying Ward's. The court concluded that under South Carolina contract law, the phrase "actual charges" is not ambiguous and must be read to mean "the charges for which the patient is liable when medical services are rendered, not the fictional amounts indicated on the invoice that the provider does not expect the patient to pay." J.A. 1074. Because Ward did not prevail on her breach of contract claims, the joint motion to decertify the class and Dixie's motion for summary judgment were denied as moot.

Ward appeals both the grant of summary judgment to National as well as the district court's decision to limit class membership to South Carolina residents. National has filed a cross-appeal contesting the district court's decision to certify even a statewide class.

II.

We begin with Ward's argument that the district court erred in concluding that, as used in her policy, the unambiguous meaning of the phrase "actual charges" is the discounted amount that medical providers have agreed to accept as full payment pursuant to a third-party agreement with another insurer. Under South Carolina law when a term has a "plain, ordinary, and popular meaning," courts must interpret the term to give effect to that

ordinary usage. *Century Indem. Co. v. Golden Hills Builders, Inc.*, 561 S.E.2d 355, 358 (S.C. 2002). When a term has a plain meaning and that meaning is "clear and unambiguous, the language [of the contract] alone determines the contract's force and effect." *Schulmeyer v. State Farm Fire & Cas. Co.*, 579 S.E.2d 132, 134 (S.C. 2003). Of course not all terms are susceptible to plain and ordinary definition because of the simple fact that they are not popularly used. As a result, a contract term is ambiguous when it lacks a plain definition and is "capable of more than one meaning when viewed objectively by a reasonably intelligent person who has examined the context of the entire integrated agreement and who is cognizant of the customs, practices, usages and terminology as generally understood in the particular trade or business." *Hansen v. United Servs. Auto. Ass'n*, 565 S.E.2d 114, 117-18 (S.C. 2002).

In the district court's endeavor to discern the plain meaning of "actual charges" as used in Ward's policy, it reasoned that the word "actual" should be given a separate meaning from the word "charges." Because the district court understood the word "actual" to mean something that is real or true, it concluded that "actual charges" means the amounts for which the patient is truly liable as opposed to "the fictional amounts indicated on the invoice that the provider does not expect the patient to pay." J.A. 1074. We disagree both with the district court's interpretive approach as well as the conclusion that it reached. The definition settled on by the district court is not the only one possible when the language of the policy is considered in light of its context. As

we explain below, the meaning of the phrase "actual charges" as used in Ward's policy is ambiguous.

First, even under the district court's approach — defining each word separately and then putting those definitions together — another meaning can reasonably be found. The words "actual charges" could also be understood to mean the amount shown on the bill sent to the patient regardless of whether this amount is the same as the amount actually owed. Viewed from within the four corners of the policy, the phrase is ambiguous as there is nothing to indicate whether "actual charges" is best understood to mean the amount actually billed or the amount actually owed. *See Conner v. Am. Pub. Life Ins. Co.*, 448 F. Supp.2d 762, 766 (N.D. Miss. 2006) (finding "inherent ambiguity in the undefined term 'actual charges'"); *Metzger v. Am. Fid. Assur. Co.*, No. CIV-05-1387-M, 2006 U.S. Dist. LEXIS 70061, at *13 (W.D. Okla. Sept. 26, 2006) (same).

Second, we disagree with the assertion that the district court was correct "in considering ordinary dictionary definitions" of both "actual" and "charges." Appellees' Br. at 21. We conclude that a person "who is cognizant of the customs, practices, usages and terminology as generally understood" in the health insurance industry would regard "actual charges" as a term of art rather than two words to be separately defined. *Hansen*, 565 S.E.2d at 117. The words are used throughout the insurance policy together as a phrase — a phrase that neither appears in a standard dictionary nor has an ordinary, popular usage. Contrary to the defendants' contention, South Carolina's principles of contract interpretation in no way prohibit courts from reading a phrase as a

term of art if that is how it would be regarded by an objective observer well-versed in medical insurance terminology. *See Frazier v. Badger*, 603 S.E.2d 587, 591 (S.C. 2004).

Third, even when viewed as a term of art, the phrase remains ambiguous. Prior to filing this lawsuit, Ward wrote to the South Carolina Department of Insurance and asked to be provided with a legal definition of "actual charge." A representative of the Department wrote back explaining that "[t]he term 'actual charge' in industry-wide standards is the amount that you are *legally obligated to pay for a specific service*." J.A. 611 (emphasis in original). In contrast to the view taken by the Department of Insurance, numerous health care dictionaries define "actual charge" as the amount billed. *See, e.g., Mosby's Medical, Nursing, and Allied Health Dictionary* 26 (4th ed. 1994) ("actual charge, the amount actually charged or billed by a medical practitioner for a service. The actual charge may not be the same as that paid for the service by an insurance plan."); Lee Hyde, *The McGraw-Hill Essential Dictionary of Health Care* 133 (1988) ("actual charge. the amount a physician or other practitioner actually *bills* a patient or his insurance for a medical *service* or *procedure*.") (emphasis in original). Because the policy itself does not indicate which definition was intended by the parties, we conclude that its meaning is ambiguous.

As the Supreme Court of South Carolina has made clear, "'Where there is ambiguity, uncertainty or doubt as to proper construction of [an insurance] contract, intention of the parties becomes a question of fact for the jury to determine.' After a

consideration of extrinsic evidence, the jury is to resolve all remaining ambiguity in favor of the insured[.]" *Waters v. S. Farm Bureau Life Ins. Co.*, 617 S.E.2d 385, 388 (S.C. 2005) (quoting *Garrett v. Pilot Life Ins. Co.*, 128 S.E.2d 171, 174 (S.C. 1962)). In light of the ambiguity of the phrase "actual charges" in the policy at issue in this case, we vacate the district court's grant of summary judgment to National and remand for further proceedings.

III.

A.

We now turn to the question of whether the district court properly limited the class of plaintiffs to those who, like Ward, are residents of South Carolina. In her motion for class certification, Ward made clear that she sought to represent persons residing throughout the southern United States who had bought policies from Dixie that were later assigned to National. Because the proposed class included non-residents of South Carolina, the district court requested briefing from the parties on the effect of South Carolina's door closing statute, S.C. Code Ann. § 15-5-150, on the potential out-of-state class members. That statute provides:

> An action against a corporation created by or under the laws of any other state government or country may be brought in the circuit court:
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S.C. Code Ann. § 15-5-150. As recently reinterpreted by the Supreme Court of South Carolina in *Farmer v. Monsanto Corp.*, 579 S.E.2d 325 (S.C. 2003), § 15-5-150 determines the capacity of a party to sue. Furthermore, *Farmer* held that "§ 15-5-150 controls the eligibility of class members in a class action where the defendant is a foreign corporation." 579 S.E.2d at 559. For suits in South Carolina state court, the effect of *Farmer* is to limit class membership to those persons who would have had capacity to sue for themselves.

In ruling on Ward's motion for class certification, the district court concluded that § 15-5-150 prevented Ward from representing out-of-state plaintiffs. The district court reached this conclusion by relying on our prior decisions stating that "a South Carolina federal court exercising diversity jurisdiction must apply § 15-5-150 'unless there are affirmative countervailing federal considerations.'" *Proctor & Schwartz, Inc. v. Rollins*, 634 F.2d 738, 739-40 (4th Cir. 1980) (quoting *Szantay v. Beech Aircraft Corporation*, 349 F.2d 60, 64 (4th Cir. 1965)). Our decisions in *Proctor & Schwartz* and *Szantay*, however, interpreted the door-closing statute in light of the then-prevailing understanding that § 15-5-150 restricted not capacity to sue but the subject matter jurisdiction of state courts. In *Farmer* the Supreme Court of South Carolina overruled its prior cases stating that § 15-5-150 dealt with jurisdiction.

In this case, we do not find it necessary to decide what effect the reinterpreted door-closing statute has on class membership in suits being heard in South Carolina federal courts sitting in diversity. This is so because, as we discuss next, Ward has failed to establish that the proposed multistate class meets Rule 23(b)(3)'s requirement that common legal issues predominate.

B.

Fed. R. Civ. P. 23 sets the requirements for class certification. First, Rule 23(a) provides that certification is proper only if

> (1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class.

Fed. R. Civ. P. 23(a). Once Rule 23(a)'s requirements of numerosity, commonality, typicality, and representational adequacy are met, the proposed class must still satisfy one of three additional requirements for certification under Rule 23(b). Because Ward sought class certification under Rule 23(b)(3), she was required to show that

> questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is

> superior to other available methods for the fair and efficient adjudication of the controversy.

Fed. R. Civ. P. 23(b)(3). The predominance requirement under Rule 23(b)(3) "is similar to but 'more stringent' than the commonality requirement of Rule 23(a)." *Thorn v. Jefferson-Pilot Life Ins. Co.*, 445 F.3d 311, 319 (4th Cir. 2006) (quoting *Lienhart v. Dryvit Sys.*, 255 F.3d 138, 146 n. 4 (4th Cir. 2001)). The party seeking class certification bears the burden of establishing all Rule 23 requirements. *In re A.H. Robins Co.*, 880 F.2d 709, 728 (4th Cir. 1989).

In her class certification memorandum, Ward stated that "members of the Class are dispersed throughout the southern United States." S.A. 12. She further noted that "Dixie marketed and sold cancer policies in at least seven states other than South Carolina, including Alabama, Florida, Georgia, Louisiana, Mississippi, Tennessee, and Texas." *Id.* Although Ward's multistate class purported to include "at a minimum, thousands of persons" across the southern United States, Ward never identified what state law would apply to the claims of absent class members who are not residents of South Carolina and whose claims have no connection to that state. *Id.* In a class action potentially governed by the laws of multiple states, identifying the applicable body or bodies of state law is critical because "variations in state law may swamp any common issues and defeat predominance." *Castano v. American Tobacco Co.*, 84 F.3d 734, 741 (5th Cir. 1996). Ward has the burden of showing "that common questions of law predominate, and [she] cannot meet this burden

when the various laws have not been identified and compared." *Gariety v. Grant Thornton, LLP*, 368 F.3d 356, 370 (4th Cir. 2004); *see also Cole v. GMC*, 484 F.3d 717, 730 (5th Cir. 2007) (decertifying a class because "[p]laintiffs have failed to adequately address, much less extensively analyze, [ ] variations in state law") (internal quotation marks and citation omitted).

Because the district court ruled on the effect of the door-closing statute before addressing the merits of Ward's motion for class certification, it did not decide whether the proposed multistate class meets the requirements of both Rule 23(a) and Rule 23(b)(3). Even assuming that this proposed class could satisfy the requirements of Rule 23(a), Ward has not established that the multistate class satisfies Rule 23(b)(3)'s requirement that common questions of law predominate. Specifically, Ward failed to identify and compare the applicable state laws. When a plaintiff seeking certification fails to provide this analysis, it is not possible for the district court to determine whether any variations in state law "pose 'insuperable obstacles' to certification" of a multistate class. *Spence v. Glock, GES.m.b.H.*, 227 F.3d 308, 313 (D.C. Cir. 2000) (quoting *Walsh v. Ford Motor Co.*, 807 F.2d 1000, 1017 (D.C. Cir. 1986)). The need in this case to identify all governing state laws and compare any variations is underscored by the decisions in two recent cases where plaintiffs in states within the proposed geographic class made claims materially similar to Ward's. In contrast to our decision today under South Carolina law, two district courts applying contract law principles of Alabama and Louisiana

concluded that the meaning of "actual charges" is unambiguous as a matter of law. See *Claybrook v. Cent. United Life Ins. Co.*, 387 F. Supp.2d 1199, 1203 (M.D. Ala. 2005); *Jarreau v. Cent. United Life Ins. Co.*, No. 05-83-FJP-SCR, 2006 U.S. Dist. LEXIS 51196 at *2 (M.D. La. May 16, 2006). In light of Ward's failure to show that common issues of law would be predominant in a multistate class, we affirm the decision of the district court to limit class membership to South Carolina residents regardless of the effect of the door-closing statute. See *United States v. Smith*, 395 F.3d 516, 519 (4th Cir. 2005) ("We are not limited to evaluation of the grounds offered by the district court to support its decision, but may affirm on any grounds apparent from the record.").

IV.

We now turn to the cross-appeal filed by National, one of the defendants. National claims that the district court abused its discretion in certifying even a statewide class because: (1) the class is not sufficiently numerous; (2) Ward is neither a typical nor adequate class representative; and (3) individual issues will predominate the determination of class members' claims. On May 19, 2005, after the statewide class had been certified but before any party had filed a motion for summary judgment, National and Dixie petitioned this court to review the district court's certification order pursuant to Fed. R. Civ. P. 23(f). This rule grants us the discretion to entertain appeals from class certification orders prior to the entry of a final judgment. *See Lienhart*, 255 F.3d at 145. Our court

applies afive-factor test to guide our discretion in deciding whether to hear such interlocutory appeals:

> (1) whether the certification ruling is likely dispositive of the litigation; (2) whether the district court's certification decision contains a substantial weakness; (3) whether the appeal will permit the resolution of an unsettled legal question of general importance; (4) the nature and status of the litigation before the district court (such as the presence of outstanding dispositive motions and the status of discovery); and (5) the likelihood that future events will make appellate review more or less appropriate.

Id. In their Rule 23(f) petition, the defendants raised the same objections to the class certification order that National now asserts in this appeal. We denied the interlocutory petition for review on June 23, 2005.

National's cross-appeal of the class certification is before us as a result of the appeal taken by the Plaintiff, Ward, from a final judgment, namely, the summary judgment awarded to defendant National. Because we have decided to vacate that judgment and remand the case for further proceedings on the merits, National's current challenge to class certification is procedurally akin to the earlier interlocutory appeal. This circumstance leads us to conclude that it would be premature for us to address the class certification issue. Earlier, when the district court certified the statewide class, it

explicitly reserved its authority to decertify or modify the class at a future date. *See McNamara v. Felderhof*, 410 F.3d 277, 281 (5th Cir. 2005) (noting that under Rule 23(c)(1)(C) the district court on remand "is free to reconsider its class certification order as often as necessary before judgment."). The defendants went on to file motions for summary judgment and for decertification of the statewide class. After the district court granted summary judgment to National, the pending motion to decertify was denied as moot. Now, in light of the remand, the district court will be able to consider the motion to decertify. Accordingly, we dismiss without prejudice the cross-appeal filed by National. *Cf. Baskin v. Hawley*, 810 F.2d 370, 371 (2d Cir. 1987) ("Prudential considerations lead to our conclusion that these appeals should be dismissed as premature notwithstanding the fact that they are taken from what was, at that time, a 'final decision[ ]' within the meaning of 28 U.S.C. § 1291.") (alteration in original).

V.

In sum, we conclude that the meaning of the phrase "actual charges" as used in Ward's policy is ambiguous. We therefore vacate the district court's grant of summary judgment to National and remand the case for further proceedings. We affirm, albeit on alternate grounds, the district court's decision to limit class membership to South Carolina residents.

Finally, we dismiss without prejudice the cross-appeal filed by National challenging the district court's certification of a statewide class.

REVERSED IN PART,
AFFIRMED IN PART,
DISMISSED IN PART,
AND REMANDED

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
COLUMBIA DIVISION

Martha Ward,	)	C/A No. 3:03-3239-JFA
	)	
Plaintiff,	)	
	)	
v.	)	
	)	
Dixie National Life	)	
Insurance Company	)	**ORDER**
and National Foundation	)	
Life Insurance Company,	)	
	)	
Defendants.	)	
	)	

This matter is before the court on the parties' cross-motions for summary judgment and a motion to decertify filed by defendant National Foundation Life Insurance Company ("National") and joined by defendant Dixie National Life Insurance Company ("Dixie"). The parties fully briefed the motions and, on April 18, 2006, the court heard extensive oral argument. For the reasons stated herein, the court grants defendant National's motion for summary judgment, thereby rendering moot the motion to decertify and defendant Dixie's motion for summary judgment. The court also denies plaintiff's motion for summary judgment.

I. BACKGROUND

On or about August 26, 1990, plaintiff Martha Ward purchased an individual cancer treatment benefit policy (the "Policy") from Dixie. Plaintiff's husband, James Ward ("James"), is listed as an insured under the Policy. The Policy is a supplemental benefits insurance policy that "provides identified benefits in the event an insured suffers a covered loss because of cancer," with benefits to be paid directly to the policyholder. The Policy states that the amount of the benefits is determined according to the "actual charges" for a particular service or treatment rendered. The term "actual charges" is neither defined in the Policy nor in any other Dixie cancer policy form. The construction of the term "actual charges" is the gravamen of the dispute.

In 1994, plaintiff was notified of the transfer of her Policy to National, and as a result, began paying her premiums to National instead of Dixie. It is undisputed that plaintiff paid all premiums due to date under the Policy. In the latter part of 2001, James was diagnosed with cancer and began receiving treatment. Plaintiff submitted claims for James's cancer treatment to National and provided the invoices from his healthcare providers as proof of loss. Initially, National adjusted and paid plaintiff the submitted claims based upon the dollar amounts stated in the providers' invoices, which amounts did not reflect the lower negotiated amounts that the provider had previously agreed to accept, and did accept, as payment in full for the services provided. Rather, in cases where a patient such as James had health insurance, the providers actually accepted as

payment in full an amount less than the amount indicated on their invoices. The providers maintain numerous agreements with various public and private health insurers in which the providers agree to accept as payment in full for their services negotiated rates lower than those indicated on their invoices. Notwithstanding the uniform charges that appear on the invoices, in reality, the negotiated rates vary from insurer to insurer.

In late 2001, National began to request the explanation of benefits forms ("EOBs") from the primary health insurer as part of its required proof of loss documentation for submitted claims. National explains that the EOBs, and not the providers' invoices, established the "loss" and the "actual charges" incurred by the insured for cancer treatment. Plaintiff refused to submit James's EOBs to National, and as a result, National refused to process the claims she submitted for his cancer treatment.

On August 14, 2002, plaintiff filed a complaint with the South Carolina Department of Insurance ("SCDOI") regarding National's request for the EOBs and the definition of "actual charges." The SCDOI responded to her on August 29, 2002, by stating in pertinent part: "Charges by providers that are discounted due to other contracts become the actual charges, as the discounted amount cannot be balanced billed to either the insurance company or the patient." The SCDOI concluded that National had handled the matter appropriately.

Plaintiff wrote a second time to the SCDOI on October 2, 2002 asking for a "legal definition" of "actual charges." On October 31, 2002, the SCDOI

responded by stating that there is "no specific definition in the South Carolina Insurance Codes and Regulations" for "actual charges." The SCDOI continued:

> Health Insurance policies are not meant to provide benefits for services for which the insured person is not legally obligated to pay. . . . Since you are not legally obligated to pay more than the State Health Plan's Allowable Charge for any specific service, National Foundation Life Insurance Company has requested copies of the State Health Plan's Explanation of Benefits (EOB's) to determine how much the provider has agreed to charge you.

The SCDOI again found that National had handled plaintiff's claims for benefits appropriately.

II. PROCEDURAL POSTURE

On March 7, 2003, plaintiff filed suit individually in state court alleging claims for breach of contract, bad faith, and breach of contract accompanied by a fraudulent act. The case was removed to this court on October 10, 2003 on the basis of diversity. Plaintiff subsequently moved to amend her complaint and sought class certification. On May 5, 2005, the court ordered class certification on the breach of contract claim, defining the "plaintiff class" as:

> All persons insured during the class period under cancer policies from

> defendant Dixie National Life Insurance Company, sold in South Carolina, where Dixie promised to pay to the insured the "actual charges" incurred for certain medical services, but where the insured was paid the amount that the insured's primary health insurer negotiated with the healthcare provider to pay for the medical procedure. The cancer policies include all cancer policies sold in the state of South Carolina regardless of the internal number assigned the policy by Dixie. Excluded from the class are the officers, directors, and employees of either of the defendants. The class period is the maximum length of time not time-barred.

Plaintiff, on behalf of herself and the class, filed a Third Amended Complaint on September 27, 2005, asserting the following claims: (1) breach of contract against both defendants; (2) bad faith refusal to pay first party claim against National;[4] and (3) breach of contract accompanied by a fraudulent act against National. In her Third Amended Complaint, plaintiff alleges that the term "actual charges" as used in her Policy and in other similar Dixie cancer policies means "benefits paid on the basis of the amount billed by the medical service provider, and

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[4] Plaintiff abandoned her bad faith claim at the hearing on April 18, 2006.

without regard to any agreements between medical service providers and third-party insurers." Plaintiff contends that National has breached the "plain language" and "unambiguous terms" of the Policy and other similar Dixie cancer policies by refusing to pay claims based upon "actual charges," as she defines it, but by instead paying based upon the "lesser amount that the insured's public or private third-party health insurer negotiated with the healthcare provider." Plaintiff is seeking compensatory damages individually and on behalf of other class members based upon the difference between the amounts stated on the providers' invoices and the amounts which National has paid as benefits under the Dixie cancer policies. Additionally, plaintiff seeks punitive damages and attorneys' fees.

III. DISCUSSION

A. SUMMARY JUDGMENT STANDARD

Summary judgment is appropriate "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). It is well established that summary judgment should be granted "only when it is clear that there is no dispute concerning either the facts of the controversy or the inferences to be drawn from those facts. *Pulliam Inv. Co. v. Cameo Properties*, 810 F.2d 1282, 1286 (4th Cir. 1987).

The party moving for summary judgment has the burden of showing the absence of a genuine issue of

material fact, and the court must view the evidence before it and the inferences to be drawn therefrom in the light most favorable to the nonmoving party. *United States v. Diebold, Inc.*, 369 U.S. 654, 655 (1962). When the defendant is the moving party and the plaintiff has the ultimate burden of proof on an issue, the defendant must identify the parts of the record that demonstrate the plaintiff lacks sufficient evidence. The nonmoving party, here the plaintiff, must then go beyond the pleadings and designate "specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56(e); *see also Celotex Corp. v. Catrett*, 477 U.S. 317 (1986).

A party "cannot create a genuine issue of material fact through mere speculation or the building of one inference upon another." *Beale v. Hardy*, 769 F.2d 213, 214 (4th Cir. 1985). Therefore, "[m]ere unsupported speculation...is not enough to defeat a summary judgment motion." *Ennis v. National Ass'n of Bus. & Educ. Radio, Inc.*, 53 F.3d 55, 62 (4th Cir. 1995).

B. PLAINTIFF'S BREACH OF CONTRACT CLAIM AGAINST NATIONAL

The material facts are not in dispute. The resolution of this case hinges on the meaning of the term "actual charges" as used in plaintiff's Policy and similar Dixie cancer policies. The construction of a clear and unambiguous insurance contract is a question of law for the court. *See S.C. Dept. of Nat. Resources v. Town of McClellanville*, 550 S.E.2d 299, 302 (S.C. 2001). Therefore, the court must first determine whether or not the Policy is ambiguous.

Plaintiff asserts that the term "actual charges" unambiguously refers to the amount a provider bills for a particular service. In her memorandum in support of her motions for summary judgment, plaintiff "concede[s] that when the evidence is construed in the light most favorable to the Defendants, the term 'actual charges' may be capable of more than one reasonable interpretation." Plaintiff relies on the various interpretations Dixie and other insurers have historically used to prove the alleged ambiguity. In addition, plaintiff points out that National itself at one time defined the term differently than it currently does, thus arguing that "actual charges" is capable of more than one reasonable interpretation. Finally, plaintiff cites to the deposition testimony of National's expert and other witnesses who define the term differently.

National argues that the court should not consider the extrinsic evidence offered by plaintiff in determining whether an ambiguity exists. Rather, National asserts that the term "actual charges" is unambiguous and should be given its plain meaning.

In construing terms of a contract, the court must first look to the language of the contract to determine the intentions of the parties. Because the court is granting summary judgment to defendant National, it must look at the evidence in the light most favorable to plaintiff. In this light, the court finds as a matter of law that the subject Policy language is unambiguous. The meaning of the term "actual charges" must be considered by reading the Policy as a whole and considering the context and

subject matter of the insurance contract.[5] Nowhere within the four corners of the Policy is the term "actual charges" used inconsistently or in a special or technical sense. Rather, the use of the term "actual charges" to mean the amounts owed to the providers as payment in full is consistent with the other language contained in the Policy. As is typical in insurance policies, the Policy only pays benefits in the event the insured suffers a "covered loss" and submits written "proof of loss." The court finds that a loss can not be construed to extend to charges for which the insured is not liable.

Furthermore, the rule of construction is that every word of a contract should be given meaning and effect if possible. See *J.A. Fay & E. Co. v. Mims*, 149 S.E. 246, 248 (S.C. 1929). The construction urged by plaintiff, that "actual charges" means whatever amount the healthcare provider puts on an invoice, would render the word "actual" meaningless, as "actual charges" would have no different meaning

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[5] The court recognizes that both defendants at one time paid claims under the Policy pursuant to the construction of "actual charges" urged by plaintiff. However, the court finds that defendants' prior actions are not to be considered in the construction of an unambiguous contract. *See Schulmeyer v. State Farm Fire & Cas. Co.*, 579 S.E.2d 132, 134 (S.C. 2003) (holding that if a contract's language is clear and unambiguous, the language alone determines the contract's force and effect); *see also, Claybrook v. Central United*, 387 F. Supp. 2d 1199 (M.D. Ala. 2005) (rejecting similar evidence and noting that subsequent conduct of the parties in observance of a contract's terms cannot be considered as aids in its construction).

from "charges." The use of the word "actual" should be given its plain and ordinary meaning in the context of the Policy. The court finds that "actual charges" are the charges for which the patient is liable when medical services are rendered, not the fictional amounts indicated on the invoice that the provider does not expect the patient to pay.

This finding is in accord with the position taken by the SCDOI. Under well-settled South Carolina law, the SCDOI's construction of the Policy is to be accorded respectful consideration and should not be overruled absent compelling reasons. *See, e.g., Dunton v. S.C. Bd. of Exam'rs in Optometry*, 353 S.E.2d 132, 133 (S.C. 1987).

Finally, at least one other federal district court has agreed with the construction urged by National and adopted by this court. In *Claybrook v. Central United*, 387 F. Supp. 2d 1199 (2005), the Alabama district court confronted a strikingly similar factual scenario,[6] with nearly the same arguments at issue. The *Claybrook* court held that the policy at issue was unambiguous and the term "actual charges" must be given its plain and ordinary meaning. The court rejected similar extrinsic evidence offered by plaintiff, holding that its analysis was confined to the "four corners of an instrument unless the

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[6] The Plaintiff initially attempted to certify a nationwide class in this case to include all of the Central United cancer policies, including the Alabama policies at issue in *Claybrook*, on grounds that the terms and benefits in the Central United policies are sufficiently similar, if not identical, to the Dixie cancer policies assumed by National in South Carolina.

instrument contains latent ambiguities." *Id.* at 1203. The *Claybrook* court found that "in everyday and plain language, the term 'actual' means 'real,' 'existing,' not 'potential' or 'possible.'" *Id.* at 1204. The undersigned finds the Claybrook court's analysis well-reasoned and persuasive.

The court, having found that National properly construes the term "actual charges" to mean the amount accepted by the healthcare provider as payment in full, finds that plaintiff's claim for breach of contract must necessarily fail. Plaintiff alleges that "Defendants breached the contract by refusing to pay Plaintiff and other class members 100% of the 'actual charges', and instead proposing to pay claims based on the reduced 'negotiated fees'." The court finds that a patient's EOB provides the necessary proof of loss for payment of benefits, because the EOB, and not the provider's invoice, shows the true cost of the service rendered and the real price paid for such service. Because National has not refused to pay the benefits owed pursuant to the terms of the Policy, as a matter of law, it cannot be found liable to plaintiff for breach of contract. Upon receipt of the requisite proof of loss from plaintiff, National has indicated its willingness to provide the benefits owed. Therefore, plaintiff cannot recover on her breach of contract claim against National, and the court grants National's motion for summary judgment.

C. PLAINTIFF'S BREACH OF CONTRACT CLAIM AGAINST DIXIE

The court finds that this order renders moot any remaining issues in Dixie's Motion for Summary Judgment. Plaintiff argues that any damages

suffered by plaintiff and the class were caused by contractual breaches by Dixie's assignee, National. Thus, plaintiff asserts that Dixie, as assignor, is liable for any wrong committed by National. As National is absolved of liability, plaintiff's breach of contract claim against Dixie is likewise dismissed. Therefore, the court need not reach the issues raised by Dixie in its motion for summary judgment.

D. PLAINTIFF'S BREACH OF CONTRACT ACCOMPANIED BY A FRAUDULENT ACT CLAIM

Because breach of contract is an essential element to plaintiff's second claim for breach of contract accompanied by a fraudulent act, the court grants summary judgment for National on plaintiff's claim.

IV. CONCLUSION

For the foregoing reasons, the court grants defendant National's motion for summary judgment [#216], and denies plaintiff's motion for summary judgment [#212]. This decision renders moot the motion to decertify [#219] and defendant Dixie's motion for summary judgment [#215].

IT IS SO ORDERED.

May 10, 2006 — s/ Joseph F. Anderson, Jr.

Columbia, South Carolina — United States District Judge

March 16, 1999

J. Earl Deaton
969 Amick's Ferry Road
Chapin, SC 29036

In Reply Refer To: 1999057-083-004
National Foundation Life Insurance Company

Dear Mr. Deaton:

We are enclosing a copy of the response received from the above-captioned company, by this Department, on March 15, 1999, to the complaint you filed with this office. We regret our response to you could not be more favorable, but based on the documentation received, it appears this matter has been handled appropriately by the company. Mr. Deaton, when a provider renders medical services to a Medicare eligible patient and accepts Medicare's assignment, they accept as their actual charge Medicare's approved allowable amount. That provider may not bill you more than the approved amount when they accept Medicare assignment. Therefore, the company needs the Medicare Explanation of Benefits to determine the "actual charges" so that the claim may be processed.

We are closing our file since we have no further jurisdiction in this matter. Thank you for the opportunity to serve you

Respectfully,

MARY ANN O'BRIEN
Insurance Regulatory Analyst
Consumer Service Division

Enclosure
cc: James Byrd
Deputy Director
Consumer Services Division

Division of Administration
Office of Consumer Services
300 Arbor Lake Drive, Suite 1200
Columbia, South Carolina 29223

Mailing Address:
P.O. Box 100105, Columbia, S.C. 29202-3105
Telephone: (803) 737-6180 or 1-800-768-3467

April 18, 2002

Mr. James Hawkins
The Methodist Oaks
Box 9005
Orangeburg, South Carolina 29116

In Reply Refer To: 112511
National Foundation Life Insurance Company

Dear Mr. Hawkins:

We are enclosing a copy of the response received from the above-captioned company, by this Department on April 18, 2002, relative to the complaint you filed with this office.

Mr. Hawkins, your insurer is requesting copies of the Medicare Explanation of Benefits to determine the allowable amount covered by Medicare. An insured or an insurer is not liable for charges, which an individual is not legally responsible for. Since you [sic] physician accepted Medicare assignment, you are not legally liable for anything over the allowable amount and therefore the insurer is not responsible for any amount over the allowable amount. This, Mr. Hawkins is standard industry practice. This company is not doing anything any

different did [sic] other carriers in the same type situation [sic].

Therefore, you must provide the Explanation of Benefits needed by the insurer for continued processing of your outstanding claims.

We trust this the [sic] information is helpful in understanding the actions of the company. We are closing our file, since we have no further jurisdiction in this matter.

Respectfully,

ALICIA CORNELIUS
Insurance Regulatory Analyst
Consumer Service Division

Enclosure

NFL NATIONAL FOUNDATION LIFE
INSURANCE COMPANY

August 9, 2002

Ms. Martha Ward
1912 Amick Drive
Gilbert, SC 29054

Re: Claimant: James A. Ward
Policy Number: 02KC598860
Claim Numbers: 021910119 and 021900142

Dear Mrs. Ward:

This is in response to your July 22, 2002, inquiry regarding the above referenced Policy. Our records indicate that you purchased a Cancer Treatment Benefit Policy that was issued with an effective date of August 26, 1990. The Policy provides benefits according to a schedule of benefits, for loss resulting from hospital confinement, or other specified expenses incurred for the treatment of Cancer. The availability of benefits is subject to the definitions, benefit provisions, exceptions and limitations. As you are aware, the majority of the benefit categories in your Policy are limited in their benefit structure to the amounts specified; however, some are not, as in the case of the "X-ray, Radium Therapy, Radiation Therapy and Chemotherapy Benefit". This benefit would be considered unlimited based on actual charges for such services. Since the Policy provides benefits on an actual charge basis, the Explanation of Benefits statements from Blue Cross/Blue Shield are required to take into consideration any discounted or written-off amounts that may have been applied to the charges that were originally

NFL NATIONAL FOUNDATION LIFE
INSURANCE COMPANY

billed. Since any amounts written-off by a provider cannot be balance billed to insurance companies or the patient, such amounts cannot be considered as actual charges. Your Policy also states that we will "...pay benefits to which you are entitled immediately upon receipt of the proof of loss supporting the claim." As the Explanation of Benefits statements from Blue Cross/Blue Shield are needed to verify your actual loss, they must be submitted in order to establish proof of loss for your claim. At this time, the above referenced claims are pending Blue Cross/Blue Shield Explanation of Benefits statements. Once these statements have been received, we will be able to continue with processing of Mr. Ward's claims. I [sic] you have any questions, please feel free to contact me directly at 1-800-221-9039, extension 455.

Sincerely,

Joan Turner
Assistant Vice President
Communications Department

ksf/JT

Martha J. Ward
1912 Amick Drive
Gilbert, SC 29054
August 14, 2002

SC Department of Insurance
Ernst N. Csiszar, Director
P.O. Box. 100105
Columbia, SC 29202

Dear Mr. Csiszar:

Please find enclosed a copy of a cancer policy that I purchased July 26, 1990 through Dixie National Life Insurance Company, which was later sold to National Foundation Life Insurance Company. The policy covers both my husband and myself. I have had the unfortunate need to make claim against this policy beginning in January of this year for my husband.

I received the indicated payment amount for the initial diagnosis by providing a pathology report. I then submitted two subsequent claims for radiation treatment attaching a UB52, which I was told was the industry standard for paying actual charges on a cancer policy. I received a request to provide EOB's for those dates of service and I explained that my policy stated "actual charges" were to be reimbursed, and that documentation had been provided along with the claim. I received payment for those two claims.

My questions are as follows:

- At the time my policy was issued, what were insurance companies required to pay when the

term "actual charges" was used to denote the amount of reimbursement?

- What type of documentation was to be provided to establish the "actual charge" of my covered procedure?

- If the definition of "actual charges" has changed since the issuance of my policy, I would like to know the date of the change and, if and how this change was to be conveyed to any affected policyholders. I have kept all of my correspondence associated with this policy and I don't have any document that indicates a change in any portion of my policy.

My intention is not to defraud anyone. My understanding of actual charges was the amount a doctor or facility charges for a procedure, not withstanding any agreements those doctors or facilities may have with my insurance provider, which my [sic] affect the amount I would owe to the doctor or facility.

I await your response.

Sincerely,

Martha J. Ward
(803) 896-6830 work
(803) 892-6545 home

SOUTH CAROLINA
DEPARTMENT OF INSURANCE

300 Arbor Lake Drive, Suite 1200
Columbus, SC 29223

P.O. Box 100105
Columbia, South Carolina 29202-3105
(803) 737-6180 or 1-800-768-3467

August 29, 2002

Ms. Martha J. Ward
1912 Amick Drive
Gilbert, SC 29054

In Reply Refer To: SC114610
National Foundation Life Insurance Company

Dear Ms. Ward:

We are enclosing a copy of the response received from the national Foundation Life Insurance Company, by this Department on August 29, 2002 to the complaint you filed with this office. We regret our response to you could not be more favorable, but based on the documentation received, it appears the company has handled this matter appropriately.

Charges by providers that are discounted due to other contracts become the actual charges, as the discounted amount cannot be balanced billed to either the insurance company or the patient.

We are closing our file since we have no further jurisdiction in this matter. Thank you for the opportunity to serve you.

Respectfully,

Bill Lemmon
Insurance Regulatory Analyst
Consumer Services Division

Enclosure

Ms. Martha J. Ward
1912 Amick Drive
Gilbert, SC 29054
October 2, 2002

SC Department of Insurance
Ernst N. Csiszar, Director
P.O. Box 100105
Columbia, SC 29202

Dear Mr. Ciszar:

This is in response to a recent correspondence by Bill Lemmon of your office. In my letter to you dated August 14, 2002, I specifically asked the SC Department of Insurance's bearing on an insurance company's obligation to pay claims when the term "actual charges" was used to denote the amount of reimbursement. My second question was, if the definition of "actual charges" has changed since the issuance of my policy, July 1990.

I do not feel that Mr. Lemmon handled my inquiry in my best interest. What I received from him was the enclosed letter dated August 29, 2002 with a response from the National Foundation Life Insurance Company dated August 27, 2002. I was already aware of National Foundation's position of my request. I am interest in the definitions of SC Department of Insurance.

I had two insurance agents who are licensed to write cancer policies in the state of South Carolina to review my policy. They both stated that they have written policies with the term "actual charges" prior

to 1992 and those policies have no bearing on a patient's benefits with any other policy they may carry. As you are aware, my policy was written, July 1990, when the State Health Insurance offered by Blue Cross-Blue Shield of SC did not have pre-negotiated reimbursement rates with physicians and/or health care providers, therefore payment was made according to the charges submitted. If National Foundation Life Insurance Company is allowed to make reimbursement changes without filing amendments to policies with the SC Department of Insurance, what keeps all other companies who wrote policies prior to 1992 the same luxury? [sic]

I would very much like to finalize this issue, therefore I am asking for an audit by your office on the reimbursement laws of cancer policies written prior to 1992 when the state health insurance company developed pre-negotiated rates with health care providers.

I await your response.

Sincerely,

Martha J. Ward
(803) 896-6830 work
(803) 892-6545 home

SOUTH CAROLINA
DEPARTMENT OF INSURANCE

300 Arbor Lake Drive, Suite 1200
Columbus, SC 29223

P.O. Box 100105
Columbia, South Carolina 29202-3105
(803) 737-6180 or 1-800-768-3467

October 31, 2002

Ms. Martha J. Ward
1912 Amick Drive
Gilbert, SC 29054

In Reply Refer To: 114810
National Foundation Life Insurance Company

Dear Ms. Ward:

You have asked that our Department provide you with a legal definition of "actual charge." There is no specific definition in the South Carolina Insurance Codes and Regulations. The term "actual charge" in industry-wide standards is the amount that you are *legally obligated to pay for a specific service.*

Under South Carolina Insurance Regulation 69-34 G (8) it is indicated that a Specified Disease and Specified Accident Insurance Coverage policy can provide benefits in one of two ways, on an expense-incurred basis or an indemnity basis.

Your Cancer Policy, purchased from Dixie National Life Insurance Company is a specified disease policy providing benefits on an expense-incurred basis.

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(4)

SUPREME COURT, U.S.
FILED
JUL 18 2008
OFFICE OF THE CLERK

No. 07-1434

IN THE

Supreme Court of the United States

DIXIE NATIONAL LIFE INSURANCE COMPANY, *et al.*,

Petitioners,

v.

MARTHA WARD, Individually and on Behalf of All Others Similarly Situated,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether the Fourth Circuit's reliance upon and adherence to South Carolina statutory and common law in declining to defer to contractual interpretations of administrative agency staff members was correct in view of the *Erie* Doctrine and traditional notions of federalism and comity.

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INTRODUCTION

Petitioners request this Court review an unpublished opinion of the Fourth Circuit that rests solely upon State law and has not resulted in the final adjudication of the case. The Fourth Circuit adhered to *Erie* principles by relying upon South Carolina law when ruling upon the central issue of this case: the interpretation of a South Carolina contract. Petitioners, however, seek a "second bite of the apple" by claiming that the Fourth Circuit *incorrectly* applied South Carolina law and, in so doing, violated the *Erie* Doctrine as well as principles of federalism and comity.

The premise for Petitioners' claim to certiorari is flawed precisely because the Fourth Circuit relied upon South Carolina law in this very State-specific case. Furthermore, the Fourth Circuit's opinion correctly applied South Carolina precedent and poses no threat of a split between the Circuits. Finally, this petition is interlocutory in nature and certiorari would serve no interest of immediate importance or judicial economy. As a result, the Petition for Writ of Certiorari presents no compelling reason supporting an exercise of this Court's jurisdiction.

COUNTERSTATEMENT OF THE CASE

During the early 1990s, Dixie National Life Insurance Company ("Dixie") wrote the supplemental cancer insurance policies at issue and sold them throughout South Carolina. These supplemental insurance policies—many of which are still in existence—differ from traditional primary care health

insurance in that they do not require the coordination of benefits with the policyholder's other insurers or with Medicare. Rather, under the terms of these supplemental policies, the insurer makes direct payments to its insureds based upon the dollar amount of "actual charges" resulting from the insured's cancer treatment.

Although used nineteen times in the policies at issue, the phrase "actual charges" is not defined. Within the medico-insurance field, "actual charges" carries a multitude of different definitions. Pet. Appx. 11a. However, at all times relevant to this case, Dixie paid benefits in a manner wholly consistent with the definition of "actual charges" as later determined by the Fourth Circuit. Pet. Appx. 6a. In 1994, Dixie assigned all its cancer policies to National Foundation Life Insurance Company ("NFL"). For the next seven years, NFL paid benefits in a manner wholly consistent with the definition of "actual charges" as determined by the Fourth Circuit. Pet. Appx. 6a. Then, in late 2001 to early 2002, NFL unilaterally changed its practice. It reduced benefit payments to equal the discounted amounts accepted by medical providers in satisfaction of the patient's bill, perforce the provider's third-party agreement with the patient's general health insurer or group plan. Pet. Appx. 7a. This change resulted in a reduction of millions of dollars in benefits paid.

Respondent Martha Ward sued to recover the difference between the actual charges billed for her husband's medical treatment and the lesser amounts paid in benefits by NFL under its new definition of actual charges in Mrs. Ward's cancer policy. She brought two

South Carolina common law causes of action still applicable to this case: breach of contract and breach of contract accompanied by a fraudulent act. Ward moved for the certification of a multi-state class of plaintiffs who purchased policies similar to hers. The District Court declined to certify a multi-state class action, but did certify a class of South Carolina policyholders. Pet. Appx. 8a. Both the Plaintiff class and Petitioners thereafter moved for summary judgment as to the meaning of the contractual term "actual charges". The District Court granted summary judgment to the Petitioners in an unpublished order, finding under State common law that the definition of "actual charges" is unambiguous and means the amount accepted by a medical provider from a third-party payor in satisfaction of the patient's bill.

The Respondent appealed the order of summary judgment and the order denying multi-state class certification to the Fourth Circuit Court of Appeals. Petitioners, meanwhile, cross-appealed the certification of the South Carolina plaintiff class. The Fourth Circuit—also in an unpublished opinion—reversed the District Court's order of summary judgment (finding the phrase "actual charges" to be ambiguous under South Carolina law) and remanded the case for trial. Pet. Appx. 4a. The Fourth Circuit also affirmed, however, the order denying multi-state class certification citing a lack of commonality in the laws of various states as they apply to Respondent's common law claims. Pet. Appx. 4a. The Court declined to address the Petitioners' cross-appeal of the South Carolina class certification, finding it to be interlocutory.

The Plaintiff petitioned the Fourth Circuit for a panel rehearing as to the issue of whether the case should be remanded for trial or whether, pursuant to South Carolina law, the ambiguity recognized by the Fourth Circuit was "patent" and required an entry of summary judgment in favor of the Plaintiff. The Fourth Circuit granted Plaintiff's petition and remanded the case to the District Court with the mandate that summary judgment be entered on behalf of Plaintiff Ward as to her breach of contract claim. Pet. Appx. 15a.

Defendants' petition for a writ of certiorari followed.

In the meantime, the parties continue to litigate this case before the District Court. While the Fourth Circuit's summary judgment mandate has been entered as to Respondent's breach of contract claim, the class's cause of action for breach of contract accompanied by a fraudulent act remains unresolved. Furthermore, while this petition for certiorari has been pending, Defendants have filed a new round of motions to dismiss before the District Court that have not been ruled upon.

SUMMARY OF THE ARGUMENT

The validity of Petitioners' request for a write of certiorari turns upon one question: whether the Fourth Circuit adhered to South Carolina law in declining to grant deference to the opinions of two South Carolina Department of Insurance staff members as to the interpretation of the contracts at issue in this case.

According to Petitioners, the portion of the Fourth Circuit's opinion giving rise to this petition is found within footnote 3.

> National and its supporting amici contend that, absent compelling reasons, we must defer to the Department of Insurance's interpretation of "actual charges." We disagree. Although an agency's interpretation of a statute it is charged with enforcing is entitled to deference, *see Dunton v. S.C. Bd. of Examiners in Optometry*, 291 S.C. 221, 353 S.E.2d 132, 133 (1987), the Department of Insurance has no statutory mandate to pronounce the meaning of a term in an individual insurance policy. We are of course interested in the Department's position, but South Carolina law does not in this case require us to defer to the Department's view of the matter.

Pet. Appx. 12a.

Petitioners insist the following "compelling reasons" exist for the Court to grant their petition: first, the Fourth Circuit's refusal to defer to the contractual interpretation of the Department of Insurance violates the *Erie* Doctrine as well as traditional notions of federalism and comity; and second, the opinion will have wide-ranging implications on insurance policies administered beyond the State of South Carolina. But as the text of the lower court's order notes, the Fourth Circuit relied upon and adhered to South Carolina law when ruling upon these South Carolina insurance

contracts at issue. Thus no compelling reasons exist for this Court to issue a writ of certiorari and the petition should be denied.

REASONS FOR DENYING THE PETITION

A. The lower court adhered to South Carolina law in declining to grant deference to the contractual interpretations of administrative agency staff

Petitioners' appeal to the *Erie* Doctrine as the basis upon which this Court should grant certiorari falls flat. Justice Brandeis wrote in *Erie* that

> Except in matters governed by the Federal Constitution or by acts of Congress, the law to be applied in any case is the law of the state. And whether the law of the state shall be declared by its Legislature in a statute or by its highest court in a decision is not a matter of federal concern.

Erie R. Co. v. Tompkins, 304 U.S. 64, 78 (1938).

Thus the crux of Petitioners' argument must be that the Fourth Circuit's offending footnote not only misapplied South Carolina law, but fundamentally ignored State precedent and statute by declining to defer to an administrative agency's interpretation of a contract. The lower court's opinion, however, both observes and closely tracks South Carolina law for three reasons: first, the Department of Insurance has no statutory authority to interpret contracts; second, at any rate, no binding agency ruling was issued in this

case; and third, South Carolina courts do not defer to the opinions of agency staff.

The Department of Insurance is an administrative agency whose duties and powers are dictated by the State Legislature via statute. *See* S.C. Code Ann. § 38-3-10, *et seq.* South Carolina courts have established that "[a]s a creature of statute, a regulatory body is possessed of only those powers expressly conferred or necessarily implied for it to effectively fulfill the duties with which it is charged." *Captain's Quarters Motor Inn, Inc. v. S.C. Coastal Council*, 413 S.E.2d 13, 14 (S.C. 1991). As the Fourth Circuit noted, the Legislature has not conferred upon the Department of Insurance the power to adjudicate the meaning of disputed contractual terms within insurance policies. Thus, under the authority cited above, no such powers exist.

Petitioners contend that the Legislature's grant of "broad regulatory authority" over the insurance industry to the Department encompasses the ability to rule upon contractual disputes. Pet. 17. But nowhere within the statutory or regulatory scheme of the Department has the Legislature even hinted at transforming the Department into a judicial body with the ability to resolve disputes of contractual interpretation. In contrast, however, it is clear that throughout the Department's existence the judiciary has operated as the sole means of resolution of insurance policy contractual disputes. *See, e.g., Coakley v. Horace Mann Ins. Co.*, 656 S.E.2d 17 (S.C. 2007) ("An insurance policy is a contract between the insured and the insurance company, and the terms of the policy are to be construed according to contract law.") Had the

Legislature intended to grant such revolutionary powers to an administrative agency, it would have done so through a clear and explicit provision rather than through the vaguely worded "broad regulatory authority" cited by Petitioners. Because no such clear and explicit provision exists, the Fourth Circuit was correct in declining to defer to the Department's contractual interpretation.

Beyond the limitations on the statutory authority of the Department of Insurance, the opinion letters touted by Petitioners as "rulings" entitled to judicial deference have no legal efficacy. The South Carolina legislature has established that "[n]o order of the director or his designee is effective unless made in writing and signed by the director or by his authority." S.C. Code Ann. § 38-3-200. A review of the documents offered by Petitioners shows that neither letter was signed by the Director of the Department of Insurance, nor do they portend to be signed by the Director's authority. Pet. Appx. 63a, 67a. Rather these letters are merely opinions of regulatory staff. Furthermore, Patricia Wuzzardo—the author of the final opinion letter attached to Petitioners' brief—later attested that she was unaware of the varying definitions of "actual charges" within the medico-insurance field and, had this facts been made known to her, she would have "consulted with counsel for the South Carolina Department of Insurance prior to submitting any response to Ms. Ward." Resp. Appx. 3a. Wuzzardo's hindsight recantation lends credence to the wisdom of South Carolina's statutory mandate that only official orders of the Director of the Department are legally effective.

Furthermore, the South Carolina Supreme Court has declined to grant deference to opinion letters from agency staff such as those in this case. "The Panel, not [agency] staff, is entitled to deference from the courts." *S.C. Coastal Conservation League v. South Carolina Dept. of Health & Env. Cntl.*, 610 S.E.2d 482 (S.C. 2005). The refusal to grant deference to staff members stems from common sense: if the staff have no binding agency authority, the agency cannot be said to have rendered a ruling on the issue at hand.

South Carolina law limits deference owed to administrative agencies to two circumstances: first, the interpretation of regulations promulgated by that agency, *see Leventis v. S.C. Dep't of Health & Envtl. Control*, 530 S.E.2d 643 (S.C. Ct. App. 2000); and second, the interpretation of a statute the agency is charged with enforcing. *See Dunton v. South Carolina Bd. of Examiners In Optometry*, 353 S.E.2d 132 (S.C. 1987). The Fourth Circuit aptly noted that neither circumstance is present in this case. Rather the Department staff letters offered by Petitioners constitute interpretations of contractual language—a function that has not been statutorily bestowed upon the Department and has been traditionally reserved for the judiciary. As a result, the lower court correctly adhered to South Carolina law in respectfully declining to grant deference to the Department's contractual interpretation.

B. Because the lower court adhered to State law, no concerns of federalism, comity or of the *Erie* Doctrine arise

The Fourth Circuit's sound reliance upon South Carolina law eliminates the concerns of the *Erie* Doctrine as well as traditional notions of federalism and comity. *Erie* stands for the proposition that "[e]xcept in matters governed by the Federal Constitution or by Acts of Congress, the law to be applied in any case is the law of the State." *Erie, supra.* Similarly, "comity and respect for federalism compel us to defer to the decisions of state courts on issues of state law." *Bush v. Gore*, 531 U.S. 98, 112 (2000) (Rehnquist, J., concurring). By adhering to South Carolina law in this case when declining to defer to the Department of Insurance, the Fourth Circuit observed the very principles that Petitioners argue merit certiorari.

Petitioners' appeal to one of the primary objectives of the *Erie* doctrine—discouragement of forum shopping—is curious, at best. All policy holders pertinent to this suit were South Carolina residents when their policies were purchased. This case was originally filed in South Carolina State court, but was removed to the federal District of South Carolina by Petitioners. The Fourth Circuit, in issuing its opinion, applied the substantive laws of the State of South Carolina. Quite simply, absolutely no forum shopping has taken place in this matter nor has the lower court impliedly encouraged future forum shopping by applying South Carolina's substantive law.

Petitioners' resort to the McCarran-Ferguson Act also rings hollow. The Act provides "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance". 15 U.S.C. § 1012(b). The Fourth Circuit did not rely upon an act of Congress in issuing its ruling and the Petitioners do not point to any such authority. Rather Petitioners contend that the lower court's failure to defer to the Department of Insurance's contractual interpretation constitutes a violation of the policy declaration of Congress. This argument may hold water if, in fact, the Fourth Circuit's opinion "invalidated, impaired, or superseded" State law. But again, the Fourth Circuit accurately *relied* upon State law and thus the McCarran-Ferguson Act is not implicated by its ruling.

The Fourth Circuit's reliance upon South Carolina law also disproves Petitioners' claims of a national, cataclysmic response to the decision below. Petitioners cite the recent case of *Guidry v. American Pub. Life Ins. Co.*, 512 F.3d 177 (5th Cir. 2007) as proof of the wide-ranging consequences of the Fourth Circuit's decision. To the contrary, however, *Guidry* specifically noted that the *Ward* opinion "applied similar rules of contract interpretation *under South Carolina law*." *Id.* at 184 (emphasis supplied). The controlling precedential effect of the Fourth Circuit's opinion is limited by the geographical scope of this suit. Because the lower court constrained its analysis to the application of South Carolina law no concerns of national interest arise. Furthermore, the Fourth Circuit chose not to publish the opinion giving rise to this petition—a decision that further mitigates Petitioners' claim of national importance.

C. The interlocutory nature of this petition weighs against granting a writ of certiorari

Petitioners ignore another compelling reason to deny review: the interlocutory nature of the ruling below. Although this Court has jurisdiction to review interlocutory decisions of federal courts of appeals under 28 U.S.C. § 1254(1), it seldom does so, and this case is not the rare case in which interlocutory review is appropriate. "Ordinarily, in the certiorari context, 'this court should not issue a writ of certiorari to review a decree of the circuit court of appeals on appeal from an interlocutory order, unless it is necessary to prevent extraordinary inconvenience and embarrassment in the conduct of the cause.'" Robert L. Stern, et al., *Supreme Court Practice* § 4.18, at 258 (8th ed. 2002) (quoting *American Constr. Co. v. Jacksonville, T. & K.W. Ry. Co.*, 148 U.S. 372, 384 (1893) (emphasis added)); *see also, e.g.*, *Hamilton Brown Shoe Co. v. Wolf Bros. Co.*, 240 U.S. 251, 258 (1916) (interlocutory decisions are reviewed only "in extraordinary cases"). The posture of this case is anything but extraordinary. The Fourth Circuit reversed the judgment of the district court on the purely legal ground that the district court erred as a matter of South Carolina law in construing the meaning of the term "actual charges" in the parties' contract. The court remanded the case to the district court for further proceedings. Within these proceedings Petitioners have filed motions to dismiss on grounds wholly unrelated to this petition—motions which, if successful, will render the proposed question presented to this Court moot.

This case is an even less appropriate vehicle for immediate, interlocutory review than was true in

Virginia Military Institute v. United States, 508 U.S. 946 (1993) (*VMI*). There, the Fourth Circuit had issued a final decision holding that the Commonwealth of Virginia's sponsorship of a military college for men only was unconstitutional, but the district court had yet to rule on the appropriate remedy. The Court denied certiorari on the ground that the decision was not sufficiently final because the remedy phase had not been completed. *See id.* at 946 (Scalia, J., concurring). The Court recognized that there would be time enough to review the decision if that were necessary after the remedial portion of the case had concluded, *id.*, and, in fact, it later did so. *See United States v. Virginia*, 518 U.S. 515 (1996). Here, as in *VMI*, there is no decision regarding the appropriate remedy, and in fact another cause of action remains in dispute. Indeed, the Fourth Circuit refused, as "premature," petitioners' effort to obtain discretionary review over their petition for permission to appeal class certification under Federal Rule of Civil Procedure 23(f). Pet. App. 22a.

Respondent believes, of course, that she will prevail on the merits. If she does, Petitioners may appeal from the district court's final decision and, ultimately, petition the Court on the same purported *Erie* question that they have presented here. *See VMI*, 508 U.S. 946 (Scalia, J., concurring). Moreover, unlike the *VMI* case, which was sui generis, here, if petitioners are correct that Fourth Circuit's ruling will affect many cases nationwide, *see* Pet. 23-27, there will be any number of future vehicles that would allow this Court to resolve the question. To be clear: as explained above, the so-called *Erie*/federalism question set forth in the petition represents an inappropriate effort to persuade this

Court to review garden-variety issues of state law. And, therefore, in our view, those questions will *never* be worthy of a place on this Court's docket. But because of the case's interlocutory status, even if the Court were to disagree with our assessment of the cert-worthiness of *the issue* posited by petitioners, the Court should stay its hand and allow *this case* to run its course.

CONCLUSION

It goes without saying that this Court does not sit to review issues of State law. S. Ct. Rule 10. In this case, the Fourth Circuit indisputably resolved only issues of South Carolina law. The question whether the contractual term "actual charges" was ambiguous was one of South Carolina state law; so, too, was the question whether that ambiguity was "patent" and thus for a court to resolve. And the question about which the petitioners premise their claim to certiorari—whether the South Carolina Department of Insurance's views are entitled to deference—was undoubtedly a question of South Carolina administrative law, as the Fourth Circuit recognized, *see* Pet. App. 12a.

Because of the Fourth Circuit's reliance upon State law, the concerns of the *Erie* Doctrine and federalism and comity are not implicated by the ruling. Furthermore, even if Petitioners' allegations of a misapplication of State law are relevant to *Erie*, they are disproven by an analysis of South Carolina law. Finally, the interlocutory nature of this petition weighs against certiorari.

For the reasons described herein, the Court should deny the petition for writ of certiorari.

Respectfully submitted,

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APPENDIX— AFFIDAVIT OF PATRICIA E. WUZZARDO

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA
COLUMBIA DIVISION

C/A NO.: 3:03-3239-JFA

Martha Ward, on behalf of herself and all others similarly situated,

Plaintiff,

vs.

Dixie National Life Insurance Company and National Foundation Life Insurance Company,

Defendants.

AFFIDAVIT OF
PATRICIA E. WUZZARDO

PERSONALLY APPEARED BEFORE ME, PATRICIA E. WUZZARDO, who after being duly sworn, deposes and states that, to the best of my knowledge:

1) I am over the age of eighteen (18) years of age, and the matters contained herein are of my own personal knowledge, unless otherwise stated.

2) I work for The South Carolina Department of Insurance as an Insurance Regulatory Analyst; I have been in this position for 15 years and have been employed by the South Carolina Department of Insurance for 15 years.

3) On October 31, 2002, I responded in writing to a complaint filed by Ms. Martha Ward regarding a cancer policy. Ms. Ward's complaint and aforementioned response is attached as **Exhibit** 1.

4) I have no recollection of reviewing Dixie National Life Insurance Company's cancer policy (CP-1001A, CP-1001, CP-1003, CP-1004, or CP-1005) or any other cancer policy similar to Ms. Ward's cancer policy prior to or after responding to Ms. Ward's complaint.

5) At the time that I responded to Ms. Ward's complaint, I was unaware of Blue Cross/Blue Shield and Medicare's definitions of "actual charges". These definitions (taken from their respective websites) are attached as **Exhibit 2**.

6) The definition of Blue Cross/Blue Shield and Medicare is in conflict with the definition or interpretation set forth in my response to Ms. Ward dated October 31, 2002.

7) If I had been aware of the definition of "actual charges" as defined by Blue Cross/Blue Shield and Medicare, I would have consulted with counsel for the South Carolina Department of Insurance prior to submitting any response to Ms. Ward.

FURTHER AFFIANT SAYETH NOT.

s/ Patricia E. Wuzzardo
PATRICIA E. WUZZARDO

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No. 07-1434

Supreme Court, U.S.
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IN THE
Supreme Court of the United States

DIXIE NATIONAL LIFE INSURANCE COMPANY AND NATIONAL FOUNDATION LIFE INSURANCE COMPANY,
Petitioners,

v.

MARTHA WARD, ON BEHALF OF HERSELF AND ALL OTHERS SIMILARLY SITUATED,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

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CORPORATE DISCLOSURE STATEMENT

The Corporate Disclosure Statement in the Petition for Writ of Certiorari filed in this case on May 16, 2008 is current as of September 10, 2008.

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INTRODUCTION

Pursuant to Rule 15.8, Petitioners respectfully submit this Supplemental Brief to bring to the Court's attention a regulatory compliance bulletin issued by the South Carolina Department of Insurance (DOI) on August 28, 2008. Bulletin No. 2008-15 is an official regulatory interpretation of newly enacted S.C. Code § 38-71-242. It explains that § 38-71-242 requires insurers to pay ***all*** claims not paid as of June 4, 2008 based on the DOI's longstanding interpretation of the term "actual charges," as that term is used in specified disease insurance policies that do not define the term.

The Bulletin provides additional support for Petitioners' argument that the Fourth Circuit's decision upsets well-established principles of state law. Under those principles, courts (including the federal judiciary) must defer to state agency interpretations. The Fourth Circuit's decision, if left standing, will undermine deep-seated principles of federalism and comity by ignoring the role of state insurance regulators and imposing harmful consequences on the insurance industry and the citizens of South Carolina. The DOI's rapidly issued Bulletin leaves no doubt about the agency's position regarding the interpretation of the term "actual charges"—a position that the Fourth Circuit erred in refusing to consider even prior to § 38-71-242. This is precisely why the Court should issue an order granting the petition, vacating the Fourth Circuit's decision, and remanding the case to the Fourth Circuit so that it has an opportunity to reconsider its decision in light of the State's new law, and the DOI's interpretation of that law.

THE REGULATORY BULLETIN

Following the Fourth Circuit's decision in this case, South Carolina enacted § 38-71-242, which statutorily defines the term "actual charges." That pivotal definition applies to all specified disease insurance policies (unless the term is defined therein), and provides that "actual charges" means the lowest amount "that the health care provider ... (a) agreed to accept ... as payment in full for the goods or services provided to the insured; [or] (b) agreed or is obligated by operation of law to accept as payment [for government administered health care programs]." S.C. Code § 38-71-242 (2008).[1]

As the agency charged with regulating the insurance industry and enforcing the insurance laws within South Carolina, the DOI has very recently issued a regulatory bulletin. Specifically, Bulletin No. 2008-15 provides official regulatory instructions concerning § 38-71-242. Such regulatory bulletins are the "method by which the Director of Insurance formally communicates with persons and entities regulated by the Department." Bulletin No. 2008-15, at 3 n.1 (reprinted in the Appendix ("App.") at 5a n.1). Regulatory bulletins provide insurance companies, consumers and courts with guidance and instruction on how the agency will interpret and enforce statutes the legislature has entrusted the DOI to administer. *Id.*; *see also* S.C. Code § 38-3-110(2) (2007) (mandating that the DOI ensure "that

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[1] S.C. Code § 38-17-242 (2008) is available at: http://www.scstatehouse.net/sess117_2007-2008/bills/1104.htm (last visited Sept. 9, 2008).

all laws of this State governing insurers or relating to the business of insurance are faithfully executed and make regulations to carry out this title and all other insurance laws of this State, the enforcement or administration of which is not otherwise specifically provided for").

Bulletin No. 2008-15 explains that § 38-71-242 "codifies the Department's longstanding interpretation of the term 'actual charges' ... in supplemental cancer policies." App. 3a. According to the Bulletin, the DOI's consistent interpretation of "actual charges" requires insurance companies "to pay benefits on an expense-incurred basis," *id.*; it does not require, as the Fourth Circuit would, insurers to pay benefits "in amounts greater than a medical provider agreed to accept as payment in full for services rendered to the insured." *Id.* at 3a-4a.

The newly-promulgated regulatory bulletin further provides that the newly-codified definition of "actual charges" is not only consistent with the DOI's longstanding interpretation of the term, but also is supported by fundamental "public policy considerations" and "basic principle[s] of insurance." *Id.* at 4a. Insurers are in the business of indemnity. That means that insureds are entitled to recover benefits only for actual out-of-pocket expenses. As the DOI recognized, its interpretation of "actual charges," now codified, implements this principle, "ensur[ing] that a few insureds and beneficiaries do not receive windfalls in the form of payments of benefits greater than sums actually paid to health care providers." *Id.* Indeed, the DOI's interpretation not only prevents windfall payments to some insureds, but it also helps to keep insurance

premiums affordable and insurance companies solvent. *Id.*

Bulletin No. 2008-15 applies § 38-71-242 to all claims not yet paid, unless a final judgment issued prior to June 4, 2008 expressly requires otherwise. Specifically, Bulletin No. 2008-15 provides that, in order to comply with § 38-71-242, "insurers that have issued supplemental cancer policies or other specified disease policy in this state containing the term(s) 'actual charge,' 'actual charges,' 'actual fee,' or 'actual fees' and that do not contain an express definition of those terms ***may not pay any claim or any benefit in excess of the amount specified in S.C. Code Ann. § 38-71-242,***" "[u]nless expressly required to do so by a final judgment issued before June 4, 2008 by a court of competent jurisdiction." *Id.* at 5a (emphasis added).

ARGUMENT

I. Bulletin No. 2008-15 Underscores The Importance Of Ensuring That Federal Courts Defer To States' Departments of Insurance.

The South Carolina legislature and the DOI have now spoken authoritatively on the issue presented in the Petition for Certiorari. As explained in Petitioners' Reply to Ward's Opposition to the Petition for Certiorari, newly enacted S.C. Code § 38-71-242 reinforces, reiterates, and codifies the DOI's longstanding interpretation of "actual charges" as the amount an insured is legally obligated to pay for services. Indeed, the South Carolina legislature enacted § 38-71-242 soon after the Fourth Circuit's decision in this case, unequivocally repudiating the

Fourth Circuit's refusal to defer to the DOI's longstanding interpretation of "actual charges."

Now, the DOI has issued Bulletin No. 2008-15 in order to provide insurance companies and their insureds immediate and authoritative guidance as to how the term "actual charges" has been, and will be, interpreted in supplemental cancer policies and the claims to which this definition applies under § 38-71-242. The Bulletin confirms that § 38-71-242 is a repudiation of the Fourth Circuit's refusal to defer to the DOI's prior interpretation of state law.

The Bulletin also underscores the error of the Fourth Circuit's approach to this case. Congress has expressly left the regulation of insurance to the authority of the States, and the South Carolina legislature has expressly granted the DOI regulatory and interpretive authority over insurance contracts. Yet the Fourth Circuit's refusal to defer to the DOI would take that authority away. Bulletin 2008-15, together with § 38-71-242, attempts to reclaim the DOI's regulatory and interpretive authority over insurance contracts.

The Bulletin makes plain that by ignoring the DOI's regulatory expertise, the Fourth Circuit endorsed an interpretation of the term "actual charges" that is based on a fundamental misunderstanding of the role of insurance contracts. As the Bulletin states, "the basic principle of insurance" is "that insurance is a contract of indemnification": "an insured must suffer an actual out-of-pocket loss to receive payment of benefits." *Id.* at 4a. The Fourth Circuit's interpretation of "actual charges," however, would have provided windfalls to some insureds "in the form of payments of benefits greater than sums actually paid to health

care providers." *Id.* These "windfalls inevitably would cause premiums to increase exponentially for all and would restrict the availability and affordability of supplemental disease policies, to the detriment of the citizens of this state." *Id.*

In § 38-71-242 and Bulletin No. 2008-15, therefore, the legislature and the DOI have now spoken. The Fourth Circuit's decision is plainly an intrusion on the regulatory expertise and authority of the DOI, and the Fourth Circuit should be instructed to reconsider its decision in light of these intervening developments.

II. Bulletin No. 2008-15 Underscores The Need For This Court To Grant The Petition, Vacate The Fourth Circuit's Decision, And Remand This Action In Light Of Section 38-71-242.

Bulletin No. 2008-15 makes clear that under § 38-71-242 Petitioners and other insurance companies ***are prohibited*** from paying claims or benefits under specified disease insurance policies in an amount that exceeds the statute's definition of "actual charges," from the date of the law's enactment, unless a court has issued a final judgment as of June 4, 2008. In other words, the Bulletin affirms that § 38-71-242 governs claims that have not yet been paid ***unless*** a final judgment has been entered to the contrary.

Thus, as the Bulletin makes clear, and as Petitioners articulated in the Reply Brief, the definition of "actual charges" embodied in § 38-71-242 must be applied in this case: the claims of the Respondent and the class members have not yet been paid and no final judgment has been entered

here. Nevertheless, in spite of the legislature's clear statutory mandate, subsequent to the filing of Petitioners' Reply Brief—but prior to the issuance of Bulletin—the District Court denied Petitioners' motion for judgment on the pleadings, which argued that § 38-71-242 must be applied to this case. Order On Motion For Judgment On The Pleadings And To Dismiss, *Ward v. Dixie Nat'l Life Ins. Co.*, No. 3:03-3239-JFA, slip op. (D.S.C. Aug. 12, 2008). The District Court rejected Petitioner's argument, concluding that it was bound by the Fourth Circuit's prior decision requiring that the term "actual charges" be construed in favor of the insured. *Id.* at *7.

The District Court's decision only compounds the Fourth Circuit's error in refusing to defer to the DOI's longstanding interpretation of the term "actual charges." A GVR in light of the statute codifying the DOI's interpretation—and in light of Bulletin No. 2008-15—is therefore warranted. Both are "intervening developments" by authoritative arms of state government that the Fourth Circuit "did not fully consider." *Lawrence v. Chater*, 516 U.S. 163, 167 (1996). Moreover, these new sources of law "reveal a reasonable probability that the decision below rests upon a premise"—namely an erroneous view of the state agency's prerogative—"that the lower court would reject if given the opportunity for further consideration." *Id.* A GVR would instructively remind the Fourth Circuit—and the entire federal judiciary—that principles of federalism matter deeply, particularly in the arena of insurance law. In that heavily regulated arena, especially in light of Congress's express deferral of regulatory authority (under its Commerce Clause

power) to the laws of the several States, the State's laws and interpretations of those laws must be respected.

CONCLUSION

For all the reasons stated in the Petition, Reply and this Supplemental Brief, this Court should grant the petition, vacate the Fourth Circuit's decision, and remand the case in light of S.C. Code § 38-71-242 and Bulletin No. 2008-15. Alternatively, the Court should grant the petition and consider the Fourth Circuit's decision on the merits.

Respectfully submitted,

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Mark Sanford
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Scott H. Richardson
Director of Insurance

Bulletin Number 2008-15

TO: All Life, Accident and Health Insurers Writing Supplemental Cancer and Other Specified Disease Policies

FROM: Scott H. Richardson, CPCU
/s/ Scott Richardson

SUBJECT: Compliance with S.C. Code Ann. § 38-71-242

DATE: August 28, 2008

I. Background

Section 38-71-242 of the South Carolina Code became effective on June 4, 2008. That section provides:

> (A)(1) When used in any individual or group specified disease insurance policy in connection with the benefits payable

for goods or services provided by any health care provider or other designated person or entity, the terms 'actual charge', 'actual charges', 'actual fee', or 'actual fees' shall mean the amount that the health care provider or other designated person or entity:

(a) agreed to accept, pursuant to a network or other agreement with a health insurer, third-party administrator, or other third-party payor, as payment in full for the goods or services provided to the insured;

(b) agreed or is obligated by operation of law to accept as payment in full for the goods or services provided to the insured pursuant to a provider, participation agreement, or supplier agreement under Medicare, Medicaid, or any other government administered health care program, where the insured is covered or reimbursed by such program; or

(c) if both subitems (a) and (b) of this subsection apply, the lowest amount determined under these two subitems; and

(2) must include any applicable deductibles, coinsurance requirements, or co-pay requirements applicable to the insured under any government administered health care program or

any private primary health insurance coverage for the health care provider's goods or services provided to the insured.

(B) This section applies to any individual or group specified disease insurance policy issued to any resident of this State that contains the terms 'actual charge', 'actual charges', 'actual fee', or 'actual fees' and does not contain an express definition for the terms 'actual charge', 'actual charges', 'actual fee', or 'actual fees'.

(C) Notwithstanding any other provision of law, after the effective date of this section, an insurer or issuer of any individual or group specified disease insurance policy shall not pay any claim or benefits based upon an actual charge, actual charges, actual fee, or actual fees under the applicable policy in an amount in excess of the 'actual charge', 'actual charges', 'actual fee', or 'actual fees' as defined in this section."

This statute codifies the Department's longstanding interpretation of the term "actual charges" or similar wording in supplemental cancer policies. For many years, spanning the terms of three directors of insurance, the Department has consistently interpreted those terms to require insurers to pay benefits on an expense-incurred basis, and not to pay benefits to insureds in amounts greater than a

medical provider agreed to accept as payment in full for services rendered to the insured.

Section 38-71-242 is based upon the same legal and public policy considerations upon which the Department has continuously relied in interpreting the term "actual charges" in supplemental disease policies. The statute embodies the basic principle of insurance, codified at S.C. Code Ann. § 38-1-20(19), that insurance is a contract of indemnification, and that an insured must suffer an actual out-of-pocket loss to receive payment of benefits. This construction of the term "actual charges" ensures that a few insureds and beneficiaries do not receive windfalls in the form of payments of benefits greater than sums actually paid to health care providers, either by insureds or beneficiaries, or by a primary health insurer. Such windfalls inevitably would cause premiums to increase exponentially for all and would restrict the availability and affordability of supplemental disease policies, to the detriment of the citizens of this state. Finally, the statue comports with the Department's consistent position that allowing payment of benefits in excess of amounts actually paid to health care providers creates opportunities for fraudulent conduct, such as deliberately inflating medical bills solely for the purpose of allowing an insured or beneficiary to collect greater benefits under a supplementary disease policy.

II. Compliance with S.C. Code Ann. § 38-71-242

Unless expressly required to do so by a final judgment issued before June 4, 2008 by a court of

competent jurisdiction, insures that have issued supplemental cancer policies or other specified disease policy in this state containing the term(s) "actual charge," "actual charges," "actual fee," or "actual fees" and that do not contain an express definition of those terms may not pay any claim or any benefit in excess of the amount specified in S.C. Code Ann. § 38-71-242.

Every insurer licensed in this state that has issued a supplemental cancer policy or other specified disease policy subject to the provisions of S.C. Code Ann. § 38-71-242 shall transmit a notice, in a form approved by the Department, to the named insured or beneficiary of each such policy informing him or her of the content of S.C. Code Ann. § 38-71-242.

III. Questions

Questions should be directed to the attention of Carla Griffin @ cgriffin@doi.sc.gov or (803) 737-6230.[1]

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[1] Bulletins are the method by which the Director of Insurance formally communicates with persons and entities regulated by the Department. Bulletins are departmental interpretations of South Carolina insurance laws and regulations and provide guidance on the Department's enforcement approach. Bulletins do not provide legal advice. Readers should consult applicable statutes and regulations or contact an attorney for legal advice or for additional information on the impact of that legislation on their specific situation.

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No. 07-1434

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

DIXIE NATIONAL LIFE INSURANCE COMPANY, *et al.*,

Petitioners,

v.

MARTHA WARD, Individually and on Behalf of All Others Similarly Situated,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

SUPPLEMENTAL BRIEF FOR RESPONDENT

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Robert L. Stern, et al., *Supreme Court Practice*
§ 4.18, at 258 (8th ed. 2002) 12

INTRODUCTION

Petitioners' supplemental brief is a misguided attempt to twist the Fourth Circuit's adherence to South Carolina law into an *Erie* dilemma. Citing S.C. Code Ann. § 38-71-242 and Department of Insurance Bulletin 2008-15—both of which emerged months after the Fourth Circuit's decision—Petitioners suggest that the Court vacate the Fourth Circuit's opinion in order to "remind the Fourth Circuit—and the entire federal judiciary—that principles of federalism matter deeply . . . [and] the State's laws and interpretations of those laws must be respected." Petitioners' Supplemental Brief, pp. 7-8. Ironically, however, Petitioners are mistaken because South Carolina law itself establishes beyond doubt that Section 38-71-242 and Bulletin 2008-15 have no bearing upon this case.

Petitioners brought their request for a writ of certiorari before the Court on May 16, 2008. On June 4, 2008, the South Carolina General Assembly enacted S.C. Code Ann. § 38-71-242, which *prospectively* defines the term "actual charges" as used in insurance policies. Whereas the Fourth Circuit remanded this case to the District Court for further proceedings, Petitioners immediately moved, on the basis of this newly enacted statute, for judgment on the pleadings of this case before the District Court. The District Court denied Petitioner's motion, finding that "general retroactivity principles provide that statutes and administrative rules are applied prospectively absent clear legislative intent to the contrary . . ." and "[n]othing in either the legislative history or the language of § 38-71-242 unambiguously indicates that the statute is to be applied

retroactively to the cases currently pending, in any form." *Ward v. Dixie National Life Ins. Co., et al.*, 3:03-cv-03239-JFA, docket entry 342 (D.S.C.).

On August 28, 2008—sixteen days after the District Court's denial of Petitioner's motion—the South Carolina Department of Insurance issued the Bulletin 2008-15. In response to this Bulletin, Petitioners filed a motion to reconsider the District Court's prior ruling, a motion for partial summary judgment, a motion to amend the Petitioner's answer, and this supplemental brief—all of which were based in part upon Bulletin 2008-15.

The District Court quickly rejected the motion for reconsideration, finding "the motion presents neither new controlling law, nor new evidence, nor points out a clear legal error of this court." *Ward v. Dixie National Life Ins. Co., et al.*, 3:03-cv-03239-JFA, docket entry 358 (D.S.C.). The Petitioners' motions to amend and for partial summary judgment, however, are still pending. Most recently, the District Court suspended all briefing deadlines in this case until November 3, 2008 pending the results of mediation between the parties now scheduled to occur on October 13, 2008. *Ward v. Dixie National Life Ins. Co., et al.*, 3:03-cv-03239-JFA, docket entry 359 (D.S.C.).

ANALYSIS OF SUPPLEMENTAL MATERIAL

Petitioners' reliance upon S.C. Code Ann. § 38-71-242 and Bulletin No. 2008-15 is fundamentally flawed in the following respects: first, Petitioners seek retroactive application of the statute by ignoring its clear and unambiguous language in a manner that would render the statute constitutionally suspect; and second, the Bulletin advanced by Petitioners as authority, in fact, has no legal effect.

Furthermore, the fact that all of these arguments are now being addressed by the District Court underscores the point that this case is particularly unsuitable for certiorari.

I. Due To The Plain Language Of The Statute And Its Prospective Application, S.C. Code Ann. § 38-71-242 Has No Relevance To The Facts Of This Case

Petitioners insist that S.C. Code Ann. § 38-71-242, along with Bulletin No. 2008-15, "unequivocally repudiated the Fourth Circuit's refusal to defer to the DOI's longstanding interpretation of "actual charges". Petitioner's Supplemental Brief, pp. 4-5. However, the plain language of the statute and South Carolina's rule of prospective statutory application render Section 38-71-242 inapplicable to the case at hand.

The pertinent statutory provision Petitioners rely upon reads as follows:

> Notwithstanding any other provision of law, **after the effective date of this section**, an insurer or issuer of any individual or group specified disease insurance policy shall not pay any claim or benefits based upon an actual charge, actual charges, actual fee, or actual fees under the applicable policy in an amount in excess of the 'actual charge', 'actual charges', 'actual fee', or 'actual fees' as defined by this section.

S.C. Code Ann. § 38-71-242(C) (emphasis supplied).

The South Carolina Supreme Court has observed that

> [i]t is a cardinal rule of statutory construction that the primary purpose in interpreting statutes is to ascertain the intent of the Legislature. . . . When a statute's terms are clear and unambiguous on their face, there is no room for statutory construction and a court must apply the statute according to its literal meaning.

Sloan v. South Carolina Bd. of Physical Therapy, 636 S.E.2d 598, 606 (S.C. 2006).

Petitioners' claim that Section 38-71-242 "repudiates the Fourth Circuit's refusal to defer to DOI's longstanding interpretation of 'actual charges'" rests upon the presumption that the statute retroactively applies to insurance contracts formed years ago. Under South Carolina's rules of statutory construction, however, effect must be given to the clear language of the clause in subsection (C) limiting the statute's scope to policies issued "after the effective date of this section" (here, June 4, 2008). Section 38-71-242 contains no language expressing any intent to abrogate vested rights on pre-existing private contractual obligations, to abate actions pending on those rights, or to nullify a federal appellate court mandate. As such, Petitioners' proposed construction stretches far beyond the plain language of the Act in derogation of the rules set forth in *Sloan*.

Furthermore, Petitioners' attempt to retroactively apply the terms of Section 38-71-242 violates fundamental precepts of the interpretation of South Carolina statutes. As explained by the South Carolina Supreme Court:

> A statute that becomes effective after the date of issuance of an insurance policy does not apply to that policy absent legislative intent that the statute be applied retroactively.
>
> A statute is not to be applied retroactively unless that result is so clearly compelled as to leave no room for doubt. The statute must contain express words evincing an intent that

> it be retroactive or words necessarily implying such an intent.

American Nat'l Fire Ins. Co. v. Smith Grading and Paving, Inc., 454 S.E.2d 897, 899 (S.C. 1995) (internal citations omitted). Section 38-71-242 contains no such "express words" and thus must be read to apply prospectively only.

Reading Section 38-71-242, as Petitioners insist, to apply retroactively would be constitutionally suspect. Both the United States and South Carolina constitutions prohibit legislative impairment of contractual rights. Although the Contract Clause does not forbid minimal alterations of contract obligations, "[s]evere impairment, on the other hand, will push the inquiry to a careful examination of the nature and purpose of the state legislation." *Allied Structural Steel Co. v. Spannaus*, 438 U.S. 234, 245 (1978) (footnote omitted).[1] In Petitioners' own words, their interpretation of Section 38-71-242 prohibits "paying claims or benefits . . . unless a court has issued a final judgment as of June 4, 2008." Petitioners' Supplemental Brief, p. 6. Depriving policyholders of millions of dollars in accrued and owing benefits is a severe impairment under any test.

The law is well-settled that statutes should be read to avoid interpretations that place their constitutionality

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1. Article I, § 4 of the South Carolina Constitution is functionally identical to its federal counterpart. "In interpreting the Contract Clause of the South Carolina Constitution, this Court has followed federal precedent construing the federal Contract Clause." *Alston v. City of Camden*, 471 S.E.2d 174, 176 (S.C. 1996).

in doubt. "Constitutional constructions of statutes are not only judicially preferred, they are mandated; a possible constitutional construction must prevail over an unconstitutional interpretation." *Henderson v. Evans*, 232 S.E.2d 331, 333 (S.C. 1977) (string citation omitted). Federal courts, of course, apply the same rule of statutory construction:

> [W]here a statute is susceptible of two constructions, by one of which grave and doubtful constitutional questions arise and by the other of which such questions are avoid, our duty is to adopt the latter.

United States ex rel. Attorney General v. Delaware & Hudson Co., 213 U.S. 366, 408 (1909). Applying this fundamental rule of statutory construction, Section 38-71-242 must be construed to apply only to insurance policies issued after the effective date of the act. Interpreting the statute otherwise would be to threaten its validity.

The law is clear that Section 38-71-242 applies prospectively to contracts entered after its passage and does not apply to the pre-existing contracts at issue in this case. Consequently, the statute does not prohibit the payment of damages sustained by the Plaintiff class due to the Petitioners' breach of the contracts at issue and does not "repudiate" the Fourth Circuit's holding.

II. Because Bulletin 2008-15 Goes Beyond The Language Of Section 38-71-242 And South Carolina Courts Grant Such Bulletins No Authority, The Department Of Insurance Interpretive Bulletin Has No Relevance To The Facts Of This Case

As shown above, the proper, prospective application of Section 38-71-242 renders the recently enacted statute inapplicable to this case. Necessarily, Bulletin 2008-15—which purports to interpret this statute—is also irrelevant. However, there are three additional reasons why this Bulletin should not affect the Court's decision as to the pending petition: first, Petitioners' construction of the Bulletin goes far beyond its own language; second, the Bulletin itself ignores the plain language of Section 38-71-242; and third, South Carolina courts have expressly found interpretive bulletins from the Department of Insurance to be non-binding.

Before addressing the legal efficacy of the interpretive bulletin, it is important to note that Petitioners' declaration of the bulletin's significance goes far beyond the plain language within its body. Petitioners assert that "the South Carolina legislature has expressly granted the DOI . . . interpretive authority over insurance contracts . . ." and "Bulletin 2008-15, together with Section 38-71-242, attempts to reclaim the DOI's regulatory and interpretive authority over insurance contracts." Petitioners' Supplemental Brief, p. 5. There are two major flaws with this assertion. First, no where within the South Carolina Code does the legislature grant the DOI—a regulatory agency—the power to interpret contracts. Second, no where within the body of the Bulletin does the Department purport

to "reclaim" any type of "interpretive authority" whatsoever. The specter of the Department of Insurance's ability to adjudicate contractual disputes is a creation of the Petitioners. Their utilization of the Bulletin to attack the lower court's ruling is premised upon the notion that "the Fourth Circuit's refusal to defer to the DOI would take that authority away." Petitioners' Supplemental Brief, p. 5. Ironically, this "authority" to interpret contracts is a notion to which even the DOI fails to subscribe.

Although the Department of Insurance does not profess to have the authority to interpret contractual provisions within Bulletin 2008-15, it does attempt to extend its regulatory authority well beyond the bounds set forth within Section 38-71-242. Notably, the Bulletin establishes the following mandate:

> Unless expressly required to do so by a final judgment issued before June 4, 2008 by a court of competent jurisdiction, insures (sic) that have issued supplemental cancer policies or other specified disease policy in this state containing the term(s) "actual charge," "actual charges," "actual fee," or "actual fees" and that do not contain an express definition of those terms may not pay any claim or any benefit in excess of the amount specified in S.C. Code Ann. § 38-71-242.

Petitioners' Supplemental Brief, pp. 4a-5a.

This is a remarkable restriction upon South Carolina insurers as its directive is not supported by the clear and unambiguous language of Section 38-71-242. Though South Carolina courts may afford agencies deference in the interpretation of statutes they administer, "where, as here, the plain language of the statute is contrary to the agency's interpretation, the Court will reject the agency's interpretation." *Brown v. Bi-Lo, Inc.*, 581 S.E.2d 836, 838 (S.C. 2003).

Even though agency interpretations are often discarded by South Carolina courts, Petitioners insist that Bulletin 2008-15 is "authoritative guidance as to how the term 'actual charges' has been, and will be, interpreted . . .". Petitioners' Supplemental Brief, p. 5. However, the South Carolina Supreme Court has specifically declared that "[a]n interpretive Bulletin [issued by the Department of Insurance] is not binding on the courts." *Garris v. Cincinnati Ins. Co.*, 311 S.E.2d 723, 726 (S.C. 1984), *rev'd on other grounds*. *Garris* involved a similar case in that the dispute centered upon the litigants' contrary interpretations of an insurance statute. The appellant insurance company based its interpretation upon a bulletin issued by the Department of Insurance. The *Garris* court refused to defer to the Department's bulletin, instead opting to observe the "clear and unambiguous" statutory language standard set forth in *Sloan*, *supra* and other cases. *Garris* at 725.

Just as in *Garris*, the interpretive bulletin authored by the Department of Insurance is not binding upon the Courts in this case. Furthermore, the directive within Bulletin 2008-15 goes far beyond the plain language of the statute it attempts to interpret. Finally, even the

non-binding language of Bulletin 2008-15 does not stretch to the point—as Petitioners insist—of "reclaiming" the Department's non-existent "interpretive authority" over insurance contracts. As such, Bulletin 2008-15 has no bearing on this case and should not affect this Court's certiorari analysis.

III. The Fourth Circuit's Careful Adherence To State Law And The Interlocutory Nature Of This Petition Renders This Case Unworthy Of Certiorari And A GVR Order Is Inappropriate

Petitioners attempt to craft a "certworthiness" argument by inventing a conflict between the Fourth Circuit's ruling and South Carolina law. Ironically, as shown above, Petitioners' appeal to a recently enacted statute and authored interpretive bulletin itself runs afoul of the South Carolina law they claim to protect.

Similarly, Petitioners' request for a GVR is also misplaced. This Court has found GVR's to be appropriate in the following situations.

> Where intervening developments, or recent developments that we have reason to believe the court below did not fully consider, reveal a reasonable probability that the decision below rests upon a premise that the lower court would reject if given the opportunity for further consideration, and where it appears that such a redetermination may determine the ultimate outcome of the litigation, a GVR order is, we believe, potentially appropriate.

Lawrence on Behalf of Lawrence v. Chater, 516 U.S. 163, 167 (1996).

Petitioners insist that the "intervening development" justifying a GVR is the DOI's interpretive Bulletin 2008-15. But as the Fourth Circuit's opinion demonstrates, it has already fully considered the position of the Department of Insurance and has declined to follow that position in accordance with South Carolina law. Petitioners' Brief, p. 12a n.3. Similarly, the above discussion of South Carolina law as it applies to the recently enacted Section 38-71-242 and Bulletin 2008-15 reveals that there is no reasonable probability the Fourth Circuit will alter their previous decision based upon this supplemental authority.

Finally, the interlocutory nature of this petition and the litigation now pending before the District Court weigh in favor of the petition's denial. Ordinarily, this Court does not grant certiorari in such cases "unless it is necessary to prevent extraordinary inconvenience and embarrassment in the conduct of the case.'" Robert L. Stern, et al., *Supreme Court Practice* § 4.18, at 258 (8th ed. 2002) (quoting *American Constr. Co. v. Jacksonville, T. & K.W. Ry. Co.*, 148 U.S. 372, 384 (1893) (emphasis added)); *see also, e.g., Hamilton Brown Shoe Co. v. Wolf Bros. Co.*, 240 U.S. 251, 258 (1916) (interlocutory decisions are reviewed only "in extraordinary cases"). Not only do such extraordinary circumstances not exist, but the District Court is currently considering the exact issues that have been presented to this Court as justification for interlocutory certiorari. If, in fact, Petitioners are correct that the Fourth Circuit will reverse its prior decision in light of Section 38-71-242 and Bulletin 2008-15, it will have ample opportunity to do so on appeal from the District Court. Furthermore, it bears repeating that this case has been scheduled for mediation on October 13, 2008 and thus may be amicably resolved within a matter of weeks.

CONCLUSION

This petition for certiorari should be denied because its fundamental premise—the presence of *Erie* concerns within the Fourth Circuit's opinion—simply does not exist. Petitioners have submitted S.C. Code Ann. § 38-71-242 and Bulletin 2008-15 as supplemental authority that they insist underscores the conflict between the Fourth Circuit and State authority. As shown above, however, South Carolina law demonstrates that both the newly-enacted statute and the bulletin have no bearing upon this case. Furthermore, the fact that this case is still pending in the District Court—and these exact issues are being argued—underscores the impropriety of certiorari in this instance.

For these reasons and those outlined in her Reply Brief, Respondent Martha Ward respectfully requests the Court deny the petition for writ of certiorari.

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IN THE
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DIXIE NATIONAL LIFE INSURANCE COMPANY AND NATIONAL FOUNDATION LIFE INSURANCE COMPANY,
Petitioners,

v.

MARTHA WARD, ON BEHALF OF HERSELF AND ALL OTHERS SIMILARLY SITUATED,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

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INTRODUCTION

Ward ignores the newly enacted S.C. Code § 38-71-242.[1] This new law, enacted on June 4, 2008, is the South Carolina legislature's response to the Fourth Circuit's decision: it repudiates that court's refusal to defer to the South Carolina Department of Insurance (DOI), and it rejects the court's erroneous interpretation of the term "actual charges," as used in specified disease insurance policies. Section 38-71-242 is an "intervening development[]" that strips the Fourth Circuit's decision of any support. *Lawrence v. Chater*, 516 U.S. 163, 167 (1996) (per curiam). This Court should issue an order granting the petition, vacating the lower court's decision, and remanding the case to the Fourth Circuit so that it has an opportunity to reconsider its decision in light of the State's new law. Reconsideration will likely change the outcome of this litigation. *See id.*

The equities favor issuance of a GVR order. While the state legislature has attempted to ameliorate the uncertainty that the Fourth Circuit's decision will have for the insurance industry, Ward has challenged below the application of the new law to this case. It clearly does apply, but even if it does not, the Fourth Circuit should reconsider its decision in light of the state legislature's strong response to its decision interpreting state law. Left standing, the Fourth Circuit's decision undermines the role of state insurance regulators and threatens the welfare

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[1] S.C. Code § 38-17-242 (2008) is available at: http://www.scstatehouse.net/sess117_2007-2008/bills/1104.htm (last visited July 29, 2008).

of insureds and the financial stability of the insurance industry in South Carolina and elsewhere. Petitioners respectfully submit that this Court should either grant the petition and consider the Fourth Circuit's decision on the merits, or in the alternative, issue a GVR order in light of S.C. Code § 38-71-242.

ARGUMENT

I. The Court Should Grant The Petition, Vacate The Decision Of The Court Of Appeals, And Remand For Consideration Of A New State Law Enacted For The Purpose Of Remedying The Fourth Circuit's Decision.

The South Carolina legislature has now spoken on the issue presented in this petition. S.C. Code § 38-71-242 reinforces, reiterates, and codifies the DOI's longstanding interpretation of "actual charges" as the amount an insured is legally obligated to pay for services. This law is a clear repudiation of the Fourth Circuit's determination that the DOI's interpretation of an ambiguous term in an insurance policy is not entitled to deference. It is also a reassertion of the State's prerogative under the McCarran-Ferguson Act to regulate the insurance industry in that State. *See* 15 U.S.C. § 1012 (2006).

In light of this "intervening development[]," this Court should issue a GVR order and send the case back to the Fourth Circuit: there is "a reasonable probability that the decision below rests upon a premise that the lower court would reject if given the opportunity for further consideration, and ... such a

redetermination may determine the ultimate outcome of the litigation ...." *Lawrence v. Chater*, 516 U.S. 163, 167 (1996) (per curiam); *see also Youngblood v. West Virginia*, 547 U.S. 867, 871 (2006) (Scalia, J., dissenting from a GVR order); *Louisiana v. Hays*, 512 U.S. 1230 (1994).

The new law creates more than a reasonable probability that the Fourth Circuit's decision would not withstand scrutiny on the merits. The Fourth Circuit concluded that the term "actual charges," as used in Ward's policy was patently ambiguous, and therefore should be interpreted in Ward's favor as requiring petitioners and other insurers to pay any amount a provider prints on a bill or invoice, regardless of whether that amount is in excess of the amount the provider intends to accept as payment in full. Section 38-71-242 rejects that definition. It provides that the DOI's well-reasoned interpretation shall be the default definition of "actual charges" whenever that term is left undefined in a specified disease insurance policy.

Ward fails to bring this intervening development to the Court's attention, but she was clearly on notice of the new law: 11 days before filing her opposition brief, Ward filed a brief in the district court arguing that § 38-71-242 does not apply to this case because her policy was issued prior to June 4, 2008. Such a position is manifestly incorrect.

Enacted just six months after the Fourth Circuit issued its decision, § 38-71-242 plainly applies to the unpaid claims pending in this litigation. Pursuant to § 38-71-242(C), "after the effective date of this section [June 4, 2008], an insurer ... shall not pay any claim or benefits based upon an actual charge ... in an amount in excess of the 'actual charge' ... as

defined in this section." This language indicates an unequivocal legislative intent that the new law govern all current and future claim or benefit payments. The law does not apply just to policies issued after the effective date of § 38-71-242; nor does it apply only to claims filed or submitted after the effective date. To the contrary, the plain language of the provision demonstrates its broad applicability to *any* claims not yet paid as of June 4, 2008, including the claims at issue in this litigation.

The South Carolina legislature carefully avoided issues of retroactivity by drafting a law that applies only to claims that have not yet been paid, and only to specified disease insurance policies that do not define the term "actual charges." *Cf. Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 207 (1988) (rejecting a federal agency's attempt to promulgate retroactive rules that would "recoup sums *previously paid*") (emphasis added). The statute thus imposes only a prospective legal obligation on insurers with respect to outstanding claims. *See Fernandez-Vargas v. Gonzales*, 548 U.S. 30, 37 (2006); *Landgraf v. USI Film Prods.*, 511 U.S. 244, 270 (1994).

Even if a court were to conclude that § 38-71-242 has a retroactive effect, that retroactive effect is entirely permissible. There is nothing improper about § 38-71-242 applying a default definition of "actual charges" to specified disease insurance policies that "do[] not contain an express definition for the term[]." S.C. Code § 38-71-242(B). The Fourth Circuit concluded only that the term "actual charges" was patently ambiguous and, therefore, under state common law rules of contract construction, must be construed in the insured's favor. Ward cannot plausibly argue that § 38-71-242

upset settled expectations, for one can hardly upset expectations in a contractual ambiguity.

These are issues that should be considered on remand by the lower courts. Ward suggests that "the interlocutory nature" of the court of appeals' decision is a "compelling reason to deny review." Opp. at 12. But the interlocutory posture makes a GVR order particularly appropriate, because application of the new law would resolve this litigation. Petitioners have already moved the district court to dismiss this litigation. That motion is pending. But even if the new law is found *not* to apply to this case, it is potentially outcome dispositive, and a GVR order is warranted because § 38-71-242 manifests the state legislature's view that the DOI's interpretation was persuasive and owed deference.

A GVR order in this case would be consistent with the Court's practice to have lower courts consider in the first instance the effect of new laws. *See Department of Justice v. City of Chicago*, 537 U.S. 1229 (2003); *Louisiana*, 512 U.S. 1230; *Missouri ex rel. Wabash Ry Co. v. Public Serv. Comm'n*, 273 U.S. 126, 130-31 (1927). Such an approach is particularly appropriate here due to the potential inequities that would fall on all South Carolina insureds if the Fourth Circuit's decision is allowed to stand, as well as "the special deference owed to state law and state courts in our system of federalism." *Stutson v. United States*, 516 U.S. 163, 179 (1996) (Scalia, J., dissenting from a GVR order); *see also Huddleston v. Dwyer*, 322 U.S. 232, 237 (1944).

II. Ward Cannot Offer Any Plausible Defense Of The Fourth Circuit's Refusal To Defer To The DOI's Well-Reasoned

Interpretation Of The Term "Actual Charges."

Ignoring the new law, Ward defends the Fourth Circuit's decision by arguing that the lower court correctly interpreted South Carolina law and properly refused to defer to the DOI's interpretation of "actual charges." Even apart from § 38-71-242, Ward's argument has no merit. The interpretation of insurance policy provisions is among the most fundamental responsibilities of a state insurance commission, as the amicus briefs submitted by the DOI and the National Association of Insurance Commissioners make clear. None of Ward's defenses of the Fourth Circuit's decision can justify its refusal to defer to the state agency.

Ward first claims that the DOI had no statutory authority to interpret a specific insurance contract provision. That contention is simply wrong. As explained in the petition and the supporting amicus briefs, South Carolina law grants the DOI broad regulatory authority over insurance policies sold within the State, *including an express statutory obligation to ensure that the terms of an insurance policy are unambiguous. See* S.C. Code Ann. § 38-61-20(A). Even under the Fourth Circuit's holding that the term "actual charges" is ambiguous, the DOI clearly would have had a statutory obligation under § 38-61-20 to disapprove the "actual charges" provision in Ward's policy. It is impossible to understand how Ward would have the DOI make such a decision if the DOI is not also permitted to *interpret* that provision.

As Ward correctly notes, "a regulatory body is possessed of ... those powers expressly conferred or

necessarily implied for it to effectively fulfill the duties with which it is charged." Opp. at 7 (quoting *Captain's Quarters Motor Inn, Inc. v. South Carolina Coastal Council*, 413 S.E.2d 13, 14 (S.C. 1991)). Here, the DOI has the statutory obligation to review and interpret insurance contracts in order to properly ensure that they do not contain ambiguous terms and insurers operating within the State are not committing violations of law by wrongfully denying claims or benefits. Where the DOI has exercised that statutory authority—in this case, by issuing opinion letters—that interpretation should be afforded deference. *See Johnson v. Beauty Unlimited Landscape Co.*, No. 4414, 2008 WL 2490449, at *1 (S.C. App. June 17, 2008); *see also South Carolina Coastal Conservation League v. South Carolina Dep't of Health & Envtl. Control*, 610 S.E.2d 482, 486 (S.C. 2005).

Because Ward cannot seriously dispute that the DOI has the legal authority to interpret insurance contracts offered and sold within South Carolina, she also suggests that the Fourth Circuit's refusal to defer was proper because the DOI is not "a judicial body with the ability to resolve disputes of contractual interpretation." Opp. at 7. With all due respect, that is a non sequitur. Whether the South Carolina legislature has granted the DOI the authority to adjudicate insurance disputes is wholly irrelevant to the question at hand. The DOI did not purport to have formally adjudicated this dispute.

In a final attempt to defend the merits of the Fourth Circuit's decision, Ward contends that the DOI's longstanding interpretation is not owed deference because the opinion letters at issue were binding agency rulings. Ward's sole support for this

contention is that § 38-3-200 requires that for an order "of the director or his designee" to be effective, it must be "signed by the director *or by his* authority." Opp. at 8 (quoting S.C. Code Ann. § 38-3-200) (emphasis added). But that statute does not require that the Director himself sign an opinion letter for it to have legal effect. Instead, the clear statutory language provides that such a ruling is effective if it is made by the Director's "designee" and signed "by [the Director's] authority." S.C. Code Ann. § 38-3-200. It defies reason to say that an opinion letter signed by a DOI analyst, who is employed at the sole discretion of the Director, *id.* § 38-3-130, did not sign that letter "by [the Director's] authority," *id.* § 38-3-200. Ward's argument is simply too cute by half.[2]

It is also beside the point. The DOI has submitted no less than five amicus briefs (one in the district court, three in the Fourth Circuit, and one in support of this petition), each of which unequivocally affirmed and reiterated the DOI's longstanding interpretation of the term "actual charges." *See Auer v. Robbins*, 519 U.S. 452, 462 (1997) (Secretary of

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[2] Ward also attempts to rely upon *South Carolina Coastal Conservation League*, 610 S.E.2d at 486, in which she contends "the South Carolina Supreme Court ... declined to grant deference to opinion letters from agency staff." Opp. at 9. Not so. That decision involved an internal agency dispute about which agency regulation applied. The state Supreme Court held that "the [agency's appellate panel] not [agency] staff, is entitled to deference from the courts." *South Carolina Coastal Conservation League*, 610 S.E.2d at 486. There is no internal agency dispute here, and Ward has no support for her novel view of administrative law.

Labor's interpretation of regulation set forth in amicus brief was entitled to deference). The DOI's view could not be clearer or more consistent.

As early as 1999, three years before the DOI began investigating Ward's dispute with National, another DOI analyst issued an opinion letter expressing the same interpretation of "actual charges." App. 55a. Contrary to Ward's suggestion, therefore, the interpretation of "actual charges" by the DOI analyst assigned to the Ward investigation was not an isolated, dissenting opinion.[3]

The South Carolina Supreme Court's decision in *Sloan v. South Carolina Board of Physical Therapy Examiners*, 636 S.E.2d 598 (S.C. 2006), which Ward ignores, confirms that an agency's interpretation of the statute it is charged with administering deserves "the most respectful consideration[, which] should not be overruled absent compelling reasons," *id.* at 607—even where the agency interpretation at issue is "nothing more than a policy or guidance statement which does not have the force or effect of law in any individual case," *id.* at 610. In other words, *Sloan* stands for the proposition that even non-final agency policy statements deserve the courts' most respectful deference under South Carolina law.

Federal courts undermine sound principles of federalism and comity when they refuse to defer to a

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3 Ward attaches an affidavit from that analyst, suggesting that the analyst's opinion letter was uninformed. Opp. App. 1-3a. Even if true, the analyst's opinion letter hardly stands alone. The DOI has expressed the same interpretation in five amicus briefs, as well as in a 1999 opinion letter.

state insurance agency's well-reasoned determination of an issue of purely state law. This Court should either grant this petition for certiorari and review it on the merits, or grant the petition, vacate the Fourth Circuit's decision, and remand the action in light of § 38-71-242.

III. The Fourth Circuit's Interpretation Of The Term "Actual Charges" Will Have A Profound National Impact On The Ability Of Insurance Commissions To Regulate The Insurance Industry.

The Fourth Circuit's decision, if allowed to stand, will interpose a federal court's judgment for that of a state insurance commission on the meaning of an unambiguous insurance policy term. The amicus briefs supporting the petition make clear that it is not simply the meaning of the term "actual charges" that is at issue in this case. Instead, at issue is the fundamental role of federal courts in an area of law left expressly to the States. Congress has admonished that the insurance industry is best regulated by the States, *see* McCarran-Ferguson Act, 15 U.S.C. § 1012(b), and insurance companies therefore rely upon state insurance commissions, their primary regulatory bodies, to provide certainty in the issuance of insurance policies.

The Fourth Circuit's decision decisively upsets this established regulatory system. It creates uncertainty surrounding any already-approved term of an insurance policy and introduces new risks that neither the state agency nor the insurance company can anticipate. As the amicus briefs explain, the Fourth Circuit's decision will have a profound national impact on the ability of state insurance

commissions to perform their regulatory obligations. This regulatory uncertainty threatens the welfare of consumers nationwide and the financial stability of the insurance industry, and warrants this Court's attention.

Ward has virtually no response, other than to suggest that the Fourth Circuit's decision "is limited by the geographical scope of this suit." Opp. at 11. But the amicus brief of the National Association of Insurance Commissioners rebuts this claim. The refusal to afford deference to one of the most fundamental responsibilities of a state insurance agency—the interpretation of insurance contract provisions—puts the insurance industry nationwide in an untenable position. It can no longer rely on commissions' approval of their policies in calculating risk and setting premiums. But risk calculations and premiums are critical to the health of the industry, and ultimately to the availability of insurance policies nationwide.

Ward does not challenge the fact that ignoring the expertise of a state agency can lead to unsound decisions that are totally at odds with the learned expertise of an agency. As the South Carolina legislature has made clear, the Fourth Circuit's decision not only introduces uncertainty but also fundamentally misunderstands modern medical billing practices. By declaring that the term "actual charges" can mean any amount a provider puts on an invoice, App. 9a-15a, the Fourth Circuit's decision assumes that patients are directly billed for medical services rendered. To the contrary, healthcare providers rarely bill a patient directly for services, but instead issue Explanations of Benefits. If insurance contracts are to have any meaning or

value, then unambiguous provisions must be interpreted to provide the coverage contracted for and approved by a state agency—no more and no less.

CONCLUSION

For the foregoing reasons, this Court should grant the petition for writ of certiorari and consider the Fourth Circuit's decision on the merits. Alternatively, the Court should grant the petition, vacate the Fourth Circuit's decision, and remand the case in light of S.C. Code § 38-71-242.

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v.

MARTHA WARD, ON BEHALF OF HERSELF AND ALL OTHERS SIMILARLY SITUATED,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF OF THE SOUTH CAROLINA DEPARTMENT OF INSURANCE AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

MOTION OF THE SOUTH CAROLINA DEPARTMENT OF INSURANCE FOR LEAVE TO FILE BRIEF AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

Pursuant to Rule 37 of the rules of this Court, the South Carolina Department of Insurance ("DOI") requests leave to file the accompanying brief as *amicus curiae* in support of the petition for writ of certiorari.

Petitioner's consent has been filed with the Clerk of Court; Respondent did not consent to the filing of this brief. All parties received timely notice of the DOI's intent to file a brief as *amicus curiae*.

This case presents the Court with the important question of whether the federal courts should insert themselves into a state law dispute an between insurers and its policyholder when the state insurance regulatory agency has issued its opinion to resolve that dispute. The United States Court of Appeals for the Fourth Circuit did just that, negating the ruling of the South Carolina Department of Insurance, a decision that the DOI had a statutory duty to make.

Full review of the judgment below is essential. The Fourth Circuit's decision stands federalism on its head by refusing to defer to the decision of a state agency exercising its statutory duty in a field that Congress has left to the states.

The DOI is the state agency directly affected by the Fourth Circuit's decision. Accordingly, the DOI respectfully requests that this Court grant its motion for leave to file the accompanying brief as amicus curiae in support of the Petitioner.

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QUESTION PRESENTED

Whether the Fourth Circuit erred by rejecting the interpretation of a South Carolina insurance policy by the South Carolina Department of Insurance, when South Carolina law has imbued that state agency with the authority and a statutory duty to approve and interpret that policy.

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On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF OF THE SOUTH CAROLINA DEPARTMENT OF INSURANCE AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

INTRODUCTION AND SUMMARY OF ARGUMENT [1]

In this case, the United States for the Fourth Circuit rewrote a supplemental cancer insurance policy. In so doing, the court of appeals threw the

[1] Counsel for a party has not authored this brief, nor has any person or entity made any monetary contribution intended to fund the preparation or submission of this brief.

market for supplemental disease policies in South Carolina into turmoil. The South Carolina Department of Insurance had approved the policy language based on its statutory duty to approve policy forms and reaffirmed its interpretation of that language in the course of exercising its statutory duty to regulate the claims practices of South Carolina insurers. The Fourth Circuit's decision unnecessarily and wrongly usurps the statutory authority of a duly constituted executive agency of the government of South Carolina.

Review of the court of appeals' decision is essential. If the holding is not reversed, the legal authority and statutory duty of the South Carolina Department of Insurance to enforce the insurance laws of South Carolina will be impaired significantly. Federal courts must defer to states in the construction of state laws and to regulatory agencies with regard to the construction of the laws that those agencies must enforce. The Fourth Circuit's failure to afford any deference whatsoever to the state of South Carolina and to its insurance regulatory agency in the construction of South Carolina insurance law will create uncertainty for the public and for the insurance industry. From a public policy perspective, the market for supplemental disease insurance policies in the state will be severely affected, pricing many, if not most, consumers out of that market.

ARGUMENT

I. The Fourth Circuit Improperly Refused to Accord the Appropriate Deference to a State Agency's Reasoned Interpretation of the Policy Pursuant to the State Statutes the Agency is Charged with Enforcing

In response to the complaints of Mrs. Ward and others, the South Carolina Department of Insurance (DOI), pursuant to its statutory duty to investigate insurers' claims practices, *see* S.C. Code Ann. § 38-59-10, -20 (2002), determined that the insurer properly adjusted and paid "actual charge" benefits under Mrs. Ward's supplemental cancer policy. Based upon, among other things, (i) the clear and unambiguous terms of the policy, (ii) the arguments of Mrs. Ward and other policyholders, (iii) the insurer's explanation of its claim payment procedures, and (iv) fundamental insurance principles, the DOI determined that "actual charges" in Mrs. Ward's policy means the charge the insured is legally obligated to pay a health care provider for its services.[2] The DOI concluded that when a health care provider's invoice or billing statement reflects an amount higher than a provider has agreed, in advance of providing services, to accept from an insured's primary health insurer (*e.g.*, Medicare) as payment in full, an insured is not entitled to receive insurance benefits based upon a higher amount reflected on the provider's invoice because that amount is not an "actual charge." The

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[2] Under a group health insurance policy, the insured is actually the group, and individuals are beneficiaries. For consistency and ease of reference, the DOI refers to beneficiaries as "insureds" in this brief.

provider's "actual charge" is the amount of money that the provider negotiated and agreed to accept as payment in full for its services. It is the money that changed hands to pay the provider.

In finding that the term "actual charges" in Mrs. Ward's cancer policy is ambiguous and "could also be understood to mean the amount shown on the bill sent to the patient regardless of whether this amount is the same as the amount actually owed," Slip Op. at 10-11, the Fourth Circuit necessarily concluded that the cancer policy requires the insurer to pay benefits to Mrs. Ward greater than the amount her health care providers negotiated and actually received as payment in full.[3] In so doing, the Fourth Circuit disregarded the express and unambiguous language of the insurance policy. Neither Mrs. Ward nor her primary health insurer was ever obligated to pay her health care providers the largest sums shown on the providers' invoices, and the health care providers never expected to collect those amounts.

Because Mrs. Ward is not required to pay – and did not pay – the sums she seeks under her policy, she has suffered no loss. The policy expressly provides that it only pays covered benefits when the insured suffers a "covered loss." Any insurance payment for a sum greater than the amount of money actually paid

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[3] The Court of Appeals correctly notes that certain health care dictionaries define "actual charges" as an amount "billed" by a health care provider. This definition is wholly consistent with the Department's position. A bill is an invoice. It sets forth an amount for which a customer, insured, or insurance company is liable. Creditors do not "bill" their debtors for amounts those debtors do not owe. In the context of this case, the amount billed is the amount the provider is legally entitled to collect – that is, the actual charge.

to a provider, therefore, would not indemnify Mrs. Ward; rather, it would be a windfall for Mrs. Ward. Insurance, however, indemnifies policyholders for covered losses; it does not bestow windfalls on insureds. The DOI thus concluded that the term "actual charges" is not ambiguous and means what it says: the charges actually and legally owed to a health care provider. Paying to receive a chance for a windfall is gambling, not insurance.

The Fourth Circuit's decision negates the DOI's reasoned determination, undermines its authority, and impairs its statutory duty. In South Carolina, the DOI is vested with broad authority to review, interpret and approve insurance contracts and their attendant premiums. *See* S.C. Code Ann. §§ 38-3-310(A)(2) (2002). Health insurers must file their policy forms with the DOI, and the DOI must approve those forms before the insurers may use them. *See* S.C. Code Ann. 38-71-720(A) (Supp. 2007). The DOI may disapprove the form if it contains a provision that it determines to be ambiguous. *See id.* § 38-71-720(A)(2). By approving the form, the DOI determined that the term "actual charges" was not ambiguous.

Group health insurers, such as the insurer in this case, are required by South Carolina law to maintain minimum reserves to pay claims. *See* S.C. Code Ann. Regs. 69-7 (2007). Were the term "actual charges" intended to mean anything other than the sum of money paid by a primary health insurer, or by the insured, to a health care provider, the DOI would have considered the claims reserves inadequate and the premiums too low for the much greater liabilities that interpretation would have created for supplemental disease insurers.

The South Carolina legislature has also given the DOI the broad authority to regulate the claims practices of South Carolina insurers. *See* S.C. Code Ann. §§ 38-59-20, -30 (2002). The DOI cannot exercise this authority without the concomitant authority to interpret disputed provisions of insurance policies. Mrs. Ward's complaint to the DOI was, in essence, that the insurer was engaging in an unfair claims practice by "misrepresenting . . . policy provisions" and failing "to pay or settle claims in full." S.C. Code Ann. §§ 38-59-20(1), (8). It was this statute that empowered the DOI to decide that the insurer was not misconstruing its policy. And it was this statute that the Fourth Circuit ignored and subverted.

The DOI's decision, made pursuant to its statutory authority, that "actual charges" means the money actually paid to a provider must be "accorded the most respectful consideration and [should] not be overruled absent compelling reasons." *See Dunton v. South Carolina Bd. of Exam'rs in Optometry*, 353 S.E.2d 132, 133 (S.C. 1987). No such compelling reasons exist in this case. The Fourth Circuit's decision does not articulate any reason, much less a compelling reason, for disregarding and subverting the DOI's determination.

This case involves an issue of significant public policy import. It calls into question the actions of the South Carolina Department of Insurance in approving the words and terms of an insurance policy and in interpreting those words and terms in response to a consumer's complaint. It is precisely the type of issue upon which a state insurance regulatory body not only *should* opine, but upon which it *must* opine. If the court of appeals' decision is allowed to stand, the Court would create a dangerous precedent. Such a

decision will send a message to both consumers and insurers in South Carolina that the DOI's approval of insurance policy forms and its policy interpretations are untrustworthy. Such a decision will discourage consumers from seeking the DOI's assistance in resolving claims disputes with their insurance companies – that is, seeking the DOI's intervention to enforce the insurance laws of South Carolina.

To avoid that result, courts must apply traditional notions of comity and judicial deference to regulatory agency interpretations. The Fourth Circuit did not do so. Federal courts must not disrupt or undermine a coherent state regulatory scheme wisely designed to protect and serve consumers and the public interest, as the United States Court of Appeals for the Fourth Circuit did.

II. The Fourth Circuit Opinion Will Harm Consumers And The Insurance Marketplace in South Carolina

Unlike the typical insurance policy construction cases routinely decided by courts, this is not a case in which a court determined that a single claim was or was not covered by a policy. Rather, this is a case in which a court changed the very essence of a policy by vastly increasing the liability of every insurance company that has issued that type of policy in South Carolina. In so doing, the Court of Appeals greatly increased the costs associated with supplemental disease policies in South Carolina, for insurers and, especially, for the majority of insureds under those policies who are not members of the class certified by the district court.

The Fourth Circuit's decision will cause a significant increase in health insurance premiums in South

Carolina. The cancer policy at issue provides coverage to hundreds of South Carolina citizens, the vast majority of whom are not members of the class and will recover nothing if Mrs. Ward prevails. If the Fourth Circuit's decision is not overturned and Mrs. Ward prevails in the district court on remand, all insureds under this cancer policy will see their premiums rise to account for the additional sums that the insurer in this lawsuit would be required to pay and for all "actual charge" claims it would pay going forward. Every other insurer with a policy that pays benefits for health care providers' "actual charges" will be forced to raise premiums to pay claims based upon whatever amounts providers decide to put on their invoices. Indeed, not long after the Fourth Circuit issued its opinion, the DOI began receiving requests for substantial rate increases from supplemental disease insurers.

Considering the skyrocketing increases in health care costs, should Mrs. Ward prevail, hundreds, and potentially thousands, of South Carolinians will be unable to maintain their health insurance coverage, either because they could not afford their portion of their employers' premiums, or because their employers find themselves priced out of the market and cease offering health insurance. Moreover, given that insurers would be required to pay "actual charge" benefits even when an insured has not suffered a loss, insurers will invariably lose the financial incentive to write health insurance policies in South Carolina. This case, therefore, may result in increased benefits for a handful of policyholders, but those benefits will be vastly outweighed by the proportional – and perhaps disproportional – decrease in the availability of affordable cancer and similar

supplemental health insurance for all South Carolina consumers.

CONCLUSION

For these reasons, amicus asks the Court to grant the petition.

Respectfully submitted,

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In The Supreme Court of the United States

DIXIE NATIONAL LIFE INSURANCE COMPANY AND NATIONAL FOUNDATION LIFE INSURANCE COMPANY,

Petitioners,

v.

MARTHA WARD, Individually and on behalf of all others similarly situated,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

MOTION FOR LEAVE TO FILE *AMICUS CURIAE BRIEF* AND BRIEF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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MOTION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF

The National Association of Insurance Commissioners ("NAIC") respectfully moves this Court, pursuant to Rule 37.2(b), for leave to file a brief as *amicus curiae* in this case in support of the Petition for a Writ of Certiorari, and in support of its motion states:

1. Counsel of record for the NAIC attempted to obtain the consent of all parties to the filing of an *amicus curiae* brief by the NAIC by contacting the parties' counsel of record.

2. The Petitioners, Dixie National Life Insurance Company and National Foundation Life Insurance Company, have consented to the filing of an *amicus curiae* brief by the NAIC through its counsel of record, Kenneth W. Starr, of Kirkland & Ellis, L.L.P.

3. The Respondent, Martha Ward, through counsel of record, Richard A. Harpootlian, of Richard A. Harpootlian, P.A., did not consent to the filing of an *amicus curiae* brief by the NAIC.

4. The NAIC has a strong interest in this case as set out fully in the brief submitted with this motion because the Fourth Circuit decision being appealed departs from the accepted and usual course of judicial proceedings, which unquestionably call for meaningful deference on matters within a regulatory agency's area of expertise.

5. The proper interpretation of the term "actual charges" stated in an insurance policy is within

the area of expertise of the South Carolina Department of Insurance, which is Congressionally delegated broad authority to regulate the business of insurance and statutorily mandated to review and approve insurance policies, identify and resolve any ambiguity, respond to consumer inquiries and investigate disputes between insurers and insureds.

6. The Fourth Circuit's decision should be taken up by this Court to rectify the explicit lack of deference given to the judgment of the South Carolina Department of Insurance.

7. As the representative of the coordinated and considered views of the state government officials that regulate and enforce the insurance laws of the country, the NAIC is uniquely qualified and situated to apprise this Court of the potential national impact of the Fourth Circuit's decision, which can be avoided if certiorari is granted.

WHEREFORE, the National Association of Insurance Commissioners respectfully moves this Court for leave to file the following brief as *amicus curiae* in support of the Petition for Writ of Certiorari.

Respectfully submitted,

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INTEREST OF *AMICUS CURIAE*[1]

1. IDENTITY OF *AMICUS CURIAE*

The National Association of Insurance Commissioners ("NAIC") is a not-for-profit Delaware corporation whose membership consists of the chief insurance regulatory officials of each state, the territories and insular possessions of the United States and the District of Columbia. Created in 1871, the NAIC is the nation's oldest association of state government officials. The mission of the NAIC is:

> [T]o assist state insurance regulators, individually and collectively, in serving the public interest and achieving the following fundamental insurance regulatory goals in a responsive, efficient and cost effective manner, consistent with the wishes of its members: promote the public interest; promote competitive markets; facilitate the fair and equitable treatment of insurance consumers; promote the reliability, solvency and financial solidity of insurance institutions; and

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[1] No counsel for a party authorized this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amicus curiae*, its members, or its counsel made a monetary contribution to its preparation or submission. Counsel of record for all parties received notice at least ten days prior to the due date of the *amicus curiae's* intention to file this brief.

support and improve state regulation of insurance.[2]

The NAIC's purpose is to provide its members with a national forum enabling them to work cooperatively on regulatory matters that transcend the boundaries of state jurisdictions. Collectively, the state insurance commissioners work to develop model legislation, rules, regulations, white papers and actuarial guidelines that promote and establish uniform regulation. Their overriding objectives are to protect consumers as well as assist in maintaining the financial stability of the insurance industry.

Any member of the NAIC may request the filing of an *amicus curiae* brief. All such requests require approval by the NAIC's Executive Committee. The Executive Committee has approved the filing of this *amicus* brief in support of the Petition for Writ of Certiorari.

2. INTEREST OF *AMICUS CURIAE*

The NAIC submits this brief to apprise the Court of the regulatory framework supporting the states' authority to regulate the business of insurance as directed by the McCarran-Ferguson Act.[3] The Supreme Court has previously considered the input of

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[2] NAIC, NAIC Mission Statement, http://www.naic.org/index_about.htm (last visited June 16, 2008).

[3] 15 U.S.C. §§ 1011-1015 (2000).

the NAIC with regard to the McCarran-Ferguson Act and stated "[t]he views of the NAIC are particularly significant, because the Act ultimately passed was based in large part on the NAIC bill."[4] The McCarran-Ferguson Act expressly directs the states to regulate the business of insurance.[5] State insurance regulators carried out the mandate of McCarran-Ferguson by developing a complex and interdependent system of regulation that applies to insurance companies, producers and service providers. Each state relies on its federal and state statutory authority to regulate insurers domiciled or selling insurance within its state to ensure protection of the consumer.

The issues before this Court affect the NAIC because the Fourth Circuit substituted its own judgment for the deliberate and reasoned decision of the South Carolina Department of Insurance. As is the case with insurance regulators across the country, as assisted by the NAIC, the Department's statutorily mandated purpose is to promote the reliability and stability of insurance institutions and ensure the fair, just and equitable treatment of policyholders and claimants. The Fourth Circuit's opinion frustrates that purpose by disregarding the judgment and questioning the statutory authority of an administrative agency. Because the Fourth Circuit failed to give appropriate deference to the Department's reasoned

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[4] Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 221 (1979).

[5] 15 U.S.C. § 1012(a) (2000).

interpretation of the term "actual charges," consumer protection is threatened. The outcome of this decision may effectively remove the interpretation of insurance policies from the Department's jurisdiction, as well as cast doubt on the ability of states to respond to consumer inquiries about policies whose content is subject to regulatory approval. The ability of the states to provide a stable and authoritative framework for approving insurance company products, forms and financial statements is necessary for the $1.4 trillion domestic insurance market[6] to function successfully. If the Court of Appeals' opinion is allowed to stand, this framework will be jeopardized.

For these reasons, the NAIC requests this Court accept the Petition for Writ of Certiorari in this case. This is consistent with statutory and common law principles and is in the best interest of insurance consumers, who commissioners protect under both federal and state law.

SUMMARY OF ARGUMENT

The Fourth Circuit Court of Appeals erred by refusing to give any deference to the South Carolina Department of Insurance's interpretation of the term "actual charges" in Respondent's supplemental cancer insurance policy, and this Court should grant the

[6] NAIC, 2006 INSURANCE DEPARTMENT RESOURCES REPORT 40 (2007).

Petition for Writ of Certiorari and reverse the decision below to correct the error below. The Fourth Circuit's decision substitutes its own judgment for that of South Carolina's Department of Insurance. This precedent violates the clear Congressional delegation of authority that underlies the broad regulatory regime enforced by South Carolina's state insurance supervisors. The Fourth Circuit misapplied well-established law that calls for deference to administrative agency judgment, and this error will have a profound national impact on the ability of state insurance departments to regulate the business of insurance. The Court of Appeals' finding that the South Carolina Department of Insurance lacked a statutory mandate to interpret Respondent's insurance policy discredits and could effectively weaken the primary function of state insurance regulation – consumer protection.

ARGUMENT

1. THE FOURTH CIRCUIT'S REFUSAL TO GRANT APPROPRIATE DEFERENCE TO THE STATE REGULATOR'S REASONED INTERPRETATION OF RESPONDENT'S SUPPLEMENTAL CANCER INSURANCE POLICY DIRECTLY UNDERMINES CONGRESS' EXPRESS DELEGATION OF AUTHORITY OVER THE BUSINESS OF INSURANCE TO THE STATES.

The McCarran-Ferguson Act was enacted in 1945 to subject the business of insurance to the laws of the several states.[7] The authority of the states to regulate the business of insurance was reaffirmed in 1999 by the passage of the Gramm-Leach-Bliley Act.[8] States regulate the business of insurance pursuant to this federal delegation and their statutory police powers. As to what constitutes the business of insurance, statutory definitions of insurance identify the underlying elements of insurance rather than provide a specific listing of insurance products.[9] For example, South Carolina defines insurance as "[a] contract

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[7] 15 U.S.C. § 1012(a) (2000).

[8] 15 U.S.C. § 6701 ("The Act entitled 'An act to express the intent of Congress with reference to the regulation of the business of insurance' and approved on March 9, 1945 ... remains the law of the United States."). 15 U.S.C. § 6711 (2000) ("[T]he insurance activities of any person ... shall be functionally regulated by the states.").

[9] NAIC, DEFINITION OF INSURANCE WORKING GROUP WHITE PAPER 2 (2000).

whereby one undertakes to indemnify another or pay a specified amount upon determinable contingencies."[10] This approach gives state insurance regulators the flexibility to tailor their regulatory practices to an industry that continuously offers new and dynamic products to consumers.

Under McCarran-Ferguson, if a practice constitutes the "business of insurance," then the state must establish laws to ensure effective regulation of that practice. Petitioners' reimbursement of expenses incurred by Respondent for cancer treatment qualifies as the business of insurance.[11] Therefore, it is appropriate for the state to regulate that activity.

A state's department of insurance is charged with enforcing and implementing state insurance laws, reviewing and approving insurance policies, resolving disputes between insureds and insurers, along with many other functions aimed at protecting consumers. For instance, the mission of the South Carolina Department of Insurance is "to protect the insurance consumers, the public interest and the insurance

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[10] S.C. CODE ANN. § 38-1-20 (2002).

[11] *See* Blackfeet v. Nelson, 171 F.3d 1237, 1246-1247 (11th Cir. 1999) ("For McCarran-Ferguson Act purposes, three-part test used for determining whether an activity constitutes part of the 'business of insurance' asks first, whether the practice has the effect of transferring or spreading a policyholder's risk, second, whether the practice is an integral part of the policy relationship between the insurer and the insured, and third, whether the practice is limited to entities within the insurance industry.").

marketplace by ensuring the solvency of insurers . . . ."[12] The Department of Insurance reviewed and approved the supplemental cancer policy at issue and, upon Respondent's inquiry, opened an investigation into her dispute with Petitioners. The investigation was concluded with two written findings, now supplemented by four briefs as *amicus curiae* in the lower courts, that Respondent's definition of "actual charges" as applied to Respondent's policy is consistent with applicable law. The Fourth Circuit's failure to give deference to South Carolina's deliberate and reasoned interpretation violates Congress's explicit delegation of authority under the McCarran-Ferguson Act to regulate the business of insurance.

To reach its conclusion, the Fourth Circuit reasoned that South Carolina did not have authority to determine the meaning of a term contained in an insurance policy. This reasoning runs contrary to Congressional intent that the states regulate the business of insurance. The Department was statutorily mandated to regulate the policy at issue. The determination that "actual charges" were discounted charges was a reasonable reading of the policy not contrary to its plain meaning. Under settled precedent, a state agency's interpretation of a statute it is charged with administering merits "the most respectful consideration and should not be overruled absent

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[12] South Carolina Department of Insurance, About the South Carolina Department of Insurance, http://www.doi.sc.gov/about/ (last visited June 16, 2008).

compelling reasons."[13] Therefore, the Fourth Circuit should have granted appropriate deference to the Department's interpretation of the policy.[14]

If the Court of Appeals' opinion is allowed to stand, it will have the effect of undermining Congress' intent that the insurance industry be regulated by state governments. The NAIC requests that the Supreme Court grant certiorari and reverse the Fourth Circuit's decision.

2. THE FOURTH CIRCUIT'S REFUSAL TO GRANT APPROPRIATE DEFERENCE TO THE STATE REGULATOR'S REASONED INTERPRETATION OF RESPONDENT'S SUPPLEMENTAL CANCER INSURANCE POLICY CHALLENGES THE MOST FUNDAMENTAL FUNCTION OF STATE INSURANCE REGULATION.

Insurance regulators are statutorily charged with protecting consumers in a number of ways: overseeing the solvency of insurance companies,[15] licensing insurance companies[16] and producers who solicit the purchase of insurance,[17] reviewing and approving

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[13] Sloan v. South Carolina Board of Physical Therapists, 636 S.E.2d 598, 607 (2006).

[14] NationsBank of N.C. v. Variable Annuity Life Ins. Co., 513 U.S. 251 (1995).

[15] *See* S.C. CODE ANN. § 38-9-10 (2002).

[16] *See, e.g.*, S.C. CODE ANN. §§ 38-5-10 to 38-5-220 (2002).

[17] *See* S.C. CODE ANN. §§ 38-43-20 to 38-43-30 (2002).

insurance products sold to consumers,[18] and investigating and examining the market practices of insurance companies.[19] These examples are merely a sample from the comprehensive statutory framework in place nationwide to carry out the twin purposes of consumer protection and marketplace solvency.

A key aspect of the regulatory responsibility delegated to the South Carolina Director of Insurance is to review and approve insurance products sold to consumers.[20] The law affords the Director full discretion to reject product filings containing "provisions which are unfair, deceptive, ambiguous, misleading, or unfairly discriminatory."[21] This type of authority, along with many more specific product requirements,[22] is in place in every state, the District of Columbia and Puerto Rico because the simple promise to pay offered by most insurance products takes the form of increasingly complex insurance policies, riders and applications, known collectively as "forms."

The regulatory review and approval of insurance forms is within the province of dedicated professional personnel in each insurance department, who are

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[18] *See* S.C. CODE ANN. § 38-61-20 (2002).

[19] *See* S.C. CODE ANN. § 38-13-10 (2002).

[20] S.C. CODE ANN. § 38-61-20 (2002).

[21] *Id.*

[22] *See, e.g.*, S.C. CODE ANN. §§ 38-63-210 to 38-63-280 (2002) (providing detailed requirements for individual life insurance policy forms).

trained to apply the specific product requirements set forth in statute and administrative regulation. These professionals also have the expertise to identify and evaluate potential areas of ambiguity in a filed form. This ability is developed through experience in reviewing and comparing countless insurance policies and understanding market trends.

Illustrative of the workload and complexity inherent in the form review and approval function is the fact that insurance departments across the country employed almost 1,200 individuals to support the actuarial and analytical aspects of form review and approval in 2006.[23] In 2007 the South Carolina Department of Insurance issued a disposition for 14,290 product filings across all types of insurance.[24]

As *amicus curiae,* the NAIC believes that the form review and approval expertise present in the South Carolina Department of Insurance lends further weight to Petitioners' argument that the Fourth Circuit erred by not deferring to the Department's interpretation of the term "actual charges." It is well established that courts must defer to regulatory agencies regarding the construction of laws those

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[23] NAIC, 2006 INSURANCE DEPARTMENT RESOURCES REPORT 7 (2007).

[24] South Carolina, South Carolina Department of Insurance Database, https://online.doi.sc.gov/Eng/Public/Queries/FlngSrch.aspx (searching for date approved/closed range of Jan. 1, 2007 to Dec. 31, 2007) (last visited June 16, 2008).

agencies enforce.[25] Likewise, federal courts sitting in diversity must defer to states regarding the construction of state laws.[26] The dismissive approach of the Fourth Circuit toward the Department's reasoned interpretation of the policy term and its ambiguity, which the Department is statutorily authorized to determine,[27] violates these axiomatic principles.

The Fourth Circuit's finding that it need not defer to the Department hinges on the perceived lack of a "statutory mandate to pronounce the meaning of a term in an individual insurance policy."[28] The Petitioners address the deficiencies in this conclusion by arguing that the Department's written interpretations and previous briefs constitute a definitive administrative finding,[29] and by pointing to the Department's broad statutory authority to investigate disputes and oversee the content and servicing of insurance in the state.[30] The NAIC as *amicus curiae* fully supports these points, and is prepared to elaborate on the statutory foundation for the activity undertaken by the Department in this case.

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[25] Dunton v. S.C. Bd. of Exam'rs in Optometry, 353 S.E.2d 132, 133 (S.C. 1987).

[26] Erie R.R. Co. v. Tompkins, 304 U.S. 64 (1938).

[27] S.C. CODE ANN. § 38-61-20 (2002).

[28] Ward v. Dixie Nat'l Life Ins. Co., 257 F. App'x 620, 626 (4th Cir. 2007).

[29] Pet'rs Br. 18.

[30] *Id.* at 17 (referring to S.C. CODE ANN. §§ 38-3-110 and 38-3-150).

The activity undertaken by the Department reflects the hallmark of state insurance regulation – responding to consumers. The broad delegation of regulatory authority embodied by the McCarran-Ferguson Act, as discussed above, necessarily includes the authority for state insurance officials to provide information to consumers about the benefits available to them through insurance products they shop for and purchase. Departments of insurance, and the NAIC on their behalf, establish and maintain many sources of information for consumers, ranging from searchable electronic databases of consumer complaints and insurer financial statements to issue-based consumer alerts and educational campaigns.

In addition to conducting form review and approval and serving as information clearinghouses, every insurance department has a statutory duty to determine and prohibit unfair and deceptive acts.[31] This function and the Department's investigatory authority rely largely on the Department's ability to receive and handle consumer inquiries and complaints. A logical outgrowth of these responsibilities is the authority to close a complaint, i.e., issue an interpretation informing a consumer that the issue or question the consumer raised does not rise to the level of an unfair trade or claims handling practice. In this case, the Department's interpretation informed the

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[31] *See, e.g.*, S.C. CODE ANN. § 38-57-10 (2002) (generally prohibiting unfair trade practices).

consumer that the definition of "actual charges" applied by the insurance company is consistent with the approved policy terms and applicable law. The Fourth Circuit's conclusion that this determination does not carry the weight of a statutorily-authorized finding calls into question this basic regulatory authority exercised daily by the Department and other insurance regulators across the country.

The fundamental nature of the Department's actions in this case is demonstrated by the depth and breadth of regulatory efforts devoted to handling consumer complaints nationwide. More than 1,700 individuals were employed by state insurance departments in the area of consumer affairs in 2006.[32] This includes 542 complaint investigators apart from the complement of investigators and other professionals in the areas of market conduct, antifraud and licensing enforcement.[33] South Carolina alone reported a staff of ten dedicated to consumer affairs.[34] Even given this level of staffing, the volume of consumer inquiries and complaints handled by state insurance departments is staggering. In 2006, insurance regulators reported receiving 393,654 consumer complaints and 2,562,064 consumer inquiries such as Respondent's.[35] It is startling to consider the resources devoted to

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[32] NAIC, 2006 INSURANCE DEPARTMENT RESOURCES REPORT 11 (2007).

[33] *Id.*

[34] *Id.*

[35] *Id.* at 66.

consumer protection given that, according to the Fourth Circuit,[36] the Department lacks statutory authority to respond to crucial policyholder questions about insurance coverage. If the Fourth Circuit's conclusion that the Department lacks statutory authority to interpret the meaning of policy terms is allowed to stand, it has the potential to destabilize a key aspect of insurance regulation and will have far reaching effects impacting all states.

CONCLUSION

The Fourth Circuit's refusal to grant appropriate deference to the Department's interpretation of the policy term at issue in this case establishes a federal precedent which undermines the vast regulatory nationwide framework of state based insurance replacing a court's judgment for the expertise of a network of insurance experts to review and approve or reject insurance products, receive complaints and resolve claims from consumers. This network is supported by a broad, Congressionally delegated statutory framework mandating oversight of insurance policies and market practices before and after insurance is purchased. Inherent in this framework is the authority to issue interpretations of policy terms, including interpretations finding that a definition

[36] Ward v. Dixie, 257 F. App'x 620, 626 at n.3 (4th Cir. 2007).

applied by the insurance company is consistent with applicable law and regulation. Absent a "compelling reason" deference should be given to the Department's interpretation of the term actual charges. To do otherwise would have an acute financial impact on the health insurance industry subjecting insurers to payment of claims for uninsured interests. This case should be accepted for certiorari to reinforce the general regulatory framework delegated to the states by the McCarran-Ferguson Act and the supporting body of law.

For the foregoing reasons, this Court should grant the Petition for Writ of Certiorari.

Respectfully submitted,

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